THE UNIVERSITY OF HULL

Perinatal Mental Health: an Exploration of Staff Perceptions and Comorbid Personality

Disorder

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Overview

This thesis portfolio comprises of three parts:

Part one: a systematic literature review, in which the available research into personality disorders during the perinatal period is reviewed. A systematic search identified 11 studies for inclusion, the findings of which are reviewed in a narrative synthesis incorporating methodological critique. Conclusions are drawn and related to the wider literature, and implications for research and practice are highlighted.

Part two: a qualitative study, in which the views of perinatal mental health staff were gathered to provide an insight into understanding of perinatal mental health problems and care. Three staff teams were interviewed using focus groups and thematic analysis was used to analyse the data, from which six themes emerged. These themes are discussed in relation to implications for practice and the wider research into perinatal mental health problems.

Part three: appendices supporting the systematic literature review and qualitative study, including an epistemological statement and a reflective statement.

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Part One: Systematic Literature Review

This paper is written in the format ready for submission to the

Infant Mental Health Journal

Please see Appendix A for the submission guidelines

Personality Disorders in the Perinatal Period: a Systematic Literature Review

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Abstract

Aim: Recent research has begun to further investigate the outcomes and risk factors associated with personality disorders and perinatal mental health problems. This review aims to bring together the current literature into personality disorders in the perinatal period, focusing on psychological outcomes relevant to mental health services.

Method: Seven online databases (Academic Search Premier, CINAHL Complete, MEDLINE, PsycARTICLES, PsycINFO, Scopus and Web of Science Core Collection) were searched for papers which explored personality disorders' prevalence during and outcomes related to the perinatal period. Of 1486 non-duplicated studies, 11 studies met inclusion criteria.

Results: Outcomes and demographic factors related to personality disorders included depression, anxiety, parenting-related stress, being single and having a low annual household income for mothers, and higher levels of emotional dysregulation for infants. There were also outcomes particularly associated with borderline personality disorder: depression, low confidence in parenting abilities, social isolation and low levels of support from current romantic partners for mothers; poorer birth outcomes and less responsive to the mother for the infant.

Conclusions: Consistent associations were found between personality disorder and: maternal mental health problems, social disadvantage, poor birth outcomes, and infant emotional development difficulties. These outcomes may not be directly attributable to personality disorder; comorbidity between personality disorder, postnatal depression and social factors should be considered. Articles were heterogeneous therefore these findings cannot be considered robust, however no contradictions were found. Demographic factors associated with personality disorder should be used to screen for women who may struggle. Intervention plans should address social factors and take a non-judgemental approach to manage stigma.

Personality Disorders in the Perinatal Period: a Systematic Literature Review

The perinatal period, defined by National Institute for Health and Clinical Excellence ('NICE') guidelines as pregnancy and the first year after a baby's birth (2016), is regarded as a significant life event bringing about changes across all areas of a woman's life (Enfoux et al, 2013). Pregnancy and childbirth are associated with increased stress in a non-clinical population (Woods, Melville, Guo, Fan & Gavin, 2010) and up to 84% of women experience a period of mild low mood of up to two weeks, commonly referred to as the 'baby blues' (O'Hara & Wisner, 2014). However, in around 10% of women, the perinatal period triggers an episode of mental illness that requires clinical attention (Hogg, 2013). The most commonly reported perinatal mental health problem is postnatal depression ('PND') (Gavin et al, 2005), however more and more research relating to perinatal anxiety, perinatal obsessive-compulsive disorder, prenatal depression, puerperal psychosis, eating disorders, and other disorders considered specific to the perinatal period has been published (Bauer, Parsonage, Knapp, Iemmi & Adelaja, 2014; O'Hara & Wisner, 2014).

Wide-ranging consequences of perinatal mental health problems are evidenced, both for the mother and the child. Perinatal mental health problems are associated with increased maternal suicidality (Heron et al, 2007; Khan, Wojdyla, Say, Gülmezoglu & Van Look, 2006; Manktelow et al, 2016), decreased maternal satisfaction (Ngai, Chan & Ip, 2010), and increased maternal social isolation (Robertson, Grace, Wallington & Stewart, 2004). There are also risks of long term emotional consequences for the child, with significantly increased risk of behavioural, social and cognitive difficulties (Hogg, 2013; Grace, Evindar & Stewart, 2003). Early life programming research (Lewis, Galbally, Gannon & Symeonides, 2014) suggests that prenatal mental health problems such as depression or stress can affect the unborn child's biological programming, leaving them significantly more susceptible to mental health difficulties as they age than individuals who were not exposed to prenatal

mental health difficulties in utero. However, maternal mental health is also an important factor postnatally, with postpartum depression being linked to negative infant outcomes such as attachment insecurity (Martins & Gaffan, 2000), socioemotional difficulties (Carter, Garrity-Rokous, Chazan-Cohen, Little & Briggs-Gowan, 2001; Feldman et al, 2009), delayed cognitive development (Cornish et al, 2005; Grace, Evindar & Stewart, 2003), and later psychiatric problems (Halligan, Murray, Martins & Cooper, 2007).

The reasoning behind these disorders occurring during the perinatal period is understood in a variety of different ways, e.g.: a biological response to hormonal imbalance (Soares & Zitek, 2008; O'Hara & Wisner, 2014); a psychosocial response to a life change (Cox, 2009; Enfoux et al, 2013); a trauma response due to unresolved developmental trauma being triggered (Newman & Stevenson, 2005; Seng, Low, Sparbel & Killion, 2004); or a diathesis-stress model of increased stress triggering an episode in those already vulnerable to mental health difficulties, such as individuals with bipolar disorder or a diagnosis of personality disorder (Jones & Craddock, 2001).

There are discussions in the literature around whether perinatal mental health problems exist independently from mental health problems generally, and indeed whether they exist to the extent described in current literature, or if they are representative of a societal tendency to pathologise the natural processes of birth and motherhood, as discussed by Cosslett (1994). Certainly discourses around perinatal mental health problems are moving away from the primarily hormonal understandings towards a more integrative biopsychosocial model (Engel, 1980), considering factors such as sleep deprivation (Park, Meltzer-Brody & Stickgold, 2013), lack of sufficient social support (Robertson, Grace, Wallington & Stewart, 2004), and pressure to be a 'good mother' (Edhborg, Friberg, Lundh & Widstrom, 2005). Evidence for postnatal depression in fathers provides additional support

to psychosocial understandings as fathers will not experience the same hormonal changes in the postnatal period (Goodman, 2003).

Personality disorder

There is a great deal of conflict within the literature regarding the validity of personality disorder as a diagnosis. The Diagnostic and Statistical Manual of Mental Disorders IV describes personality disorder as "*an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment* "(American Psychiatric Association [APA], 2013, p. 629). Issues with the diagnostic label relate to the variability of symptomology within diagnosis (Arntz, 1999), the high prevalence of personality disorder (Grant et al, 2008; Torgersen, Kringlen & Cramer, 2001), and diagnostic overlap both within personality disorder clusters (DSM-IV: APA, 2013) and with other disorders (Grant et al, 2008; Zanari et al, 1998). Some studies report that personality disorder is more of an unhelpful and pejorative 'umbrella' term rather than a useful clinical diagnosis (Lewis & Appleby, 1988), leading clinicians to make judgements based on stigma rather than clinical presentation (Newton-Howes, Weaver & Tyrer, 2008) and providing a barrier to seeking support (Hadfield & Wittkowski, 2017; Staneva, Bogossian & Wittkowski, 2015). The International Statistical Classification of Diseases and Related Health Problems (volume 11; 'ICD-11'; World Health Organisation, 2018) intends to reclassify personality disorders as a spectrum in terms of severity, and describe what was previously understood as separate personality disorders as 'domain traits', of which multiple or none can be expressed by an individual. This is more in line with a formulation-based approach and allows for individual difference.

However, there is some evidence to suggest that personality disorder is a stable construct over time (Paris, 2003). Additionally, specific therapeutic approaches such as Dialectical Behaviour Therapy (Linehan, 1987) have been built up around the diagnosis that appear effective, suggest it can be a helpful framework for understanding and treating mental illnesses which appear to fit within this diagnosis (Panos, Jackson, Hasan & Panos, 2013).

While acknowledging the problematic nature of the diagnosis of personality disorder, this review will employ the term 'personality disorder' as defined by the DSM-IV, both because it is widely used in clinical practice and as it affords a means of identifying literature which addresses women with a particular group of symptoms.

Personality disorder as a risk factor for perinatal mental health problems is increasingly becoming a focus for research as links are established between personality disorder diagnosis and increased frequency and severity of perinatal mental health problems (Akman, Uguz & Kaya, 2007; Enatescu et al, 2016; di Giacomo, Colmegna & Clerici, 2017). Clinically, individuals with a diagnosis of personality disorder often represent a 'hard to engage' client group as a result of a variety of factors including low self-efficacy, poor relationships with staff, emotional dysregulation and avoidance (Tetley, Jinks, Huband, Howells & McMurran, 2012). There is not yet specific research into the effects of personality disorder on engagement with perinatal mental health services, however staff report noting a higher incidence of personality disorder diagnoses within harder to reach client groups (Steele, 2018). They also report these clients groups to be more vulnerable and to take up more clinical time through assertive outreach, and also note a generational effect within this client group (Steele, 2018). The importance of research into this client group is therefore important on a variety of levels; individually for personal recovery, on a service level to optimise provision, and on a societal level to minimise impact on the infant and future generations.

A scoping exercise identified that borderline (or, more recently, 'emotionally unstable'; ICD-10, World Health Organisation, 1992) personality disorder appears to be the most extensively researched personality disorder in relation to perinatal mental health and motherhood; of 37 papers including the key terms 'personality disorder' and variations of 'perinatal mental health', 19 related specifically to borderline personality disorder and all others related to personality disorder in general rather than any other specific personality disorder. However there are as yet no sufficiently large reviews to confirm that it is the most commonly associated with perinatal mental health problems, and little is currently known about the impact of other personality disorder diagnoses.

Mothers with a diagnosis of borderline personality disorder are considered to be more likely to experience difficulty parenting than mothers without a diagnosis of personality disorder (Newman & Stevenson, 2005), and are less likely to use contraception and more likely to experience unplanned pregnancy than women without a diagnosis of borderline personality disorder (De Genna, Feske, Larkby, Angiolieri & Gold, 2012), which is a risk factor for perinatal mental health problems (Gipson, Koenig & Hindin, 2008; Najman, Morrison, Williams, Anderson & Keeping, 1991). The infants of mothers with a diagnosis of borderline personality disorder are more likely to present with a disorganised attachment style (Hobson, Patrick, Crandell, Garcia-Perez & Lee, 2005), which is associated with mental health problems later in life (van Ijzendoorn, Schuengel & Bakermans-Kranenburg, 1999).

Study aims

Recent research has begun to further investigate the outcomes and risk factors associated with personality disorders and perinatal mental health problems. However as yet there have been no large-scale studies or reviews collating findings beyond small, isolated

populations, making the literature hard to generalise. Given the insufficient rationale for the inclusion and exclusion of specific types of personality disorder (as defined by the DSM-IV), all personality disorders were included.

This review therefore aims to conduct a narrative synthesis bringing together the current literature into personality disorders in the perinatal period, with an aim of using this information clinically to identify the population at risk, inform preventative measures, and to target interventions.

The research question for this review was: what research has been conducted into personality disorders in the perinatal period, and what are the findings so far?

Method

Search strategy

In accordance with PRISMA guidelines (Liberati et al, 2009), electronic database searches were performed using Academic Search Premier, CINAHL Complete, MEDLINE, PsycARTICLES, PsycINFO, Scopus, Web of Science Core Collection. Search terms were generated after scoping the literature and the following search terms were used: ("personality disorder" or BPD) AND (puerperal OR perinatal OR prenatal OR postnatal OR peripartum OR intrapartum OR antenatal OR prepartum OR antepartum) NOT bronchopulmonary dysplasia NOT biparietal diameter. These final exclusions were included as they are also abbreviated to BPD. BPD was included in addition to personality disorders in general as it is a frequently used abbreviation, whereas other personality disorders are more commonly referred to in full and are therefore included in a search for 'personality disorders'.

Study selection

Inclusion criteria applied for this review were as follows: (a) research relating specifically to the perinatal period as per NICE guidelines, (b) research relating specifically to personality disorder (i.e. including a personality disorder group in their sample, as identified by screening tools or diagnostic measures) (c) peer-reviewed articles, (d) research published in English-language journals, and (e) randomised, non-randomised (experimental) and cohort studies. Editorial letters, commentaries, conference abstracts, discussion articles, clinical drug investigations, incidence studies and non-systematic literature reviews were excluded. Duplicates were removed. Titles and abstracts were then screened for potential inclusion. Full-text articles were retrieved from all abstracts that were potentially relevant, and screened for inclusion or exclusion. A final sample of 11 studies remained. Figure 1 summarises the article selection process in full.
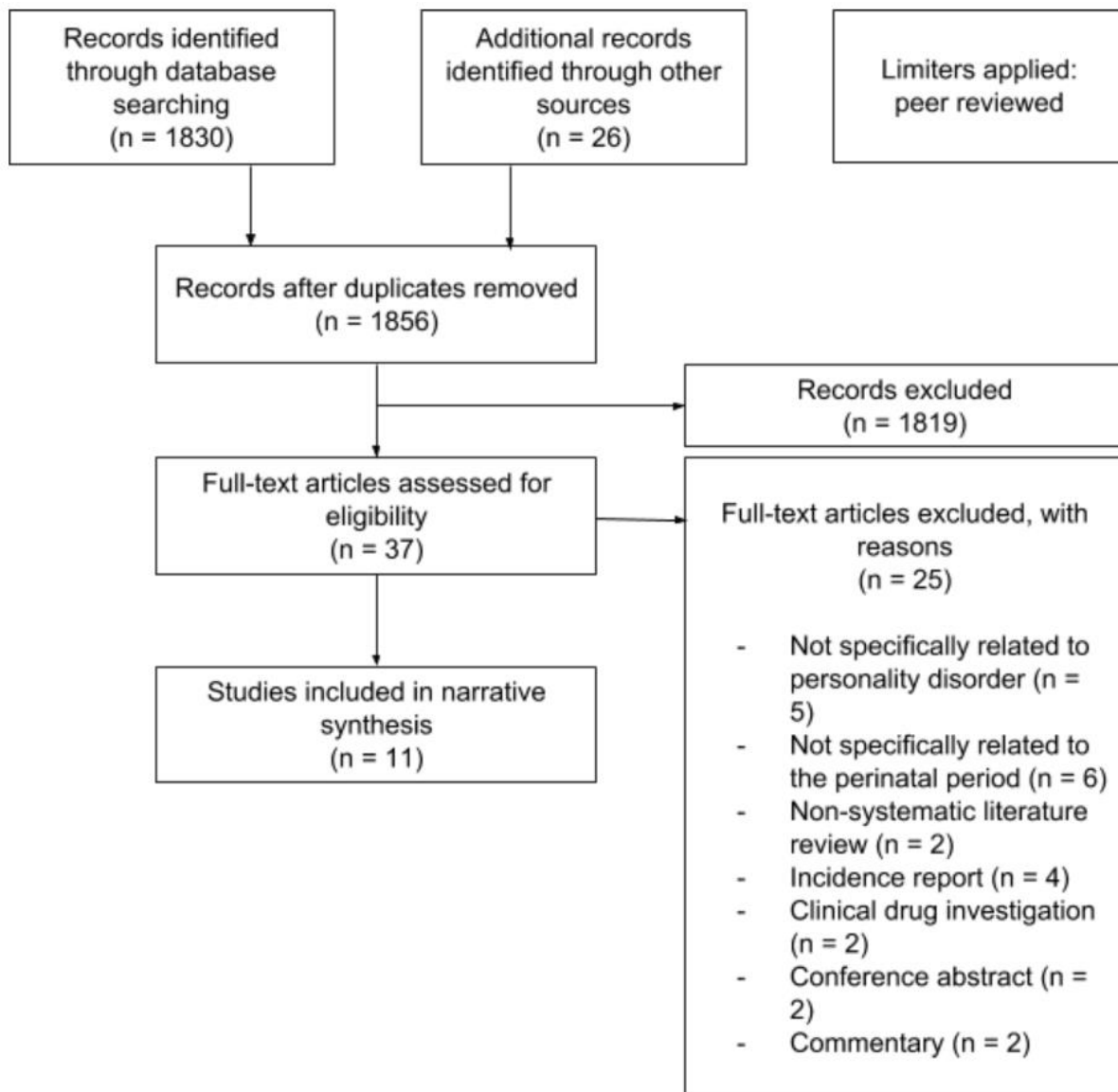
Figure 1. Flowchart depicting the study selection process

Data extraction

Data was extracted into a data extraction form (Appendix B) containing information on study title, study authors and year of publication, geographical area of study, aim of study, participant characteristics, study design, results relating to personality disorder in the perinatal period, conclusions and interpretations, outcome measures, statistical analysis, limitations, and quality assessment score.

Study quality assessment

Methodological quality was assessed using a checklist devised by the author (Appendix C), including items from Downs and Black (1998); Strengthening the Reporting of Observational Studies in Epidemiology ('STROBE'; Von Elm et al, 2007); Mixed Methods Appraisal Tool ('MMAT'; Pace et al, 2012); Critical Appraisal Skills Programmes ('CASP') checklists (CASP, 2017); and National Institute for Health and Care Excellence ('NICE') quality appraisal tools (NICE, 2006). The author compiled the above checklists to ensure a comprehensive assessment, collating all questions from all checklists and removing duplicates. The checklist was created in this way to ensure all aspects of methodological quality were assessed, as the studies in this review employed a variety of methodologies and did not fit neatly into any pre-existing category of checklist aside from the MMAT, which may be susceptible to ceiling effects due to its brevity. The heterogeneity of the sample was accounted for within the checklist by the use of a percentage total and the possibility of scoring items as 'not applicable', which removed the item from the total used to create the percentage total. Finally a random sample of 5 articles was chosen and blindly rated for quality by an independent peer reviewer. Interrater reliability assessment was carried out (Cohen's Kappa = .74, 'substantial agreement'; Landis & Koch, 1977). Discrepancies in ratings were discussed and final decisions on quality scores were made collaboratively.

Data analysis

Due to the heterogeneity of studies included, a narrative synthesis methodology was chosen over a meta-analysis. This method allows findings from studies using a variety of methodologies and operationalising concepts in different ways to be compared and summarised through text, as opposed to amalgamating homogenous data for statistical

analysis. Guidance developed by Popay, Rogers and Williams (2006) was used to inform this process. Data were collected using the data extraction tool (Appendix B) were collated into a table with summaries of their key findings. Key findings were categorised by topic and compared, summarised and critiqued in a narrative format. Quality assessment scores were also used to contextualise findings.

Overview of included studies

Table 1 presents a summary of the articles included in this review.

Table 1

Summary of included studies

Authors, date, country	Aims	Design	Participant characteristics	Outcomes and measures (see legend for abbreviations)	Key relevant findings	Quality rating
Apter, Devouche, Gratier, Valente & Nestour (2012) France	Investigate whether there is a greater incidence of personality disorder among a PND population than among non-PND, 3 months postpartum. Secondary aim: define different types of personality disorder.	Between group comparison	Women with 12-week-old infants, n = 109	Montgomery-Asberg Depression Rating Scale, SCID-II	60% of depressed mothers met criteria for a personality disorder compared to 30% of non-depressed mothers. PND associated with a greater number of severe clinical symptoms. Cluster B (DSM-IV: APA, 2013) personality disorders (especially borderline personality disorder) most strongly associated with	87%

					PND. Women meeting diagnostic criteria for paranoid, avoidant and borderline personality disorders more often depressed during the postpartum period than not.	
Blankley, Galbally, Snellen, Power & Lewis (2015) Australia	Investigate infant and maternal outcomes of borderline personality disorder in the perinatal period	Retrospective, comparative case review	Pregnant women with a clinical diagnosis of borderline personality disorder, presenting for obstetric services, n = 42 Control group without diagnosis recruited from the same service, n = 14,313	Care attendance, infant outcomes (Apgar, admission to special care nursery), staff concerns, referral to other services, DSM-IV diagnosis	Mothers with a diagnosis of borderline personality disorder: considerable psychosocial impairment, anticipate birth as traumatic, frequently request early delivery, high comorbid substance abuse, high rate of referral to child protective services, negative birth outcomes more likely (low Apgar, prematurity, special care nursery referral).	89%
Conroy, Marks, Schacht, Davies & Moran (2009) UK	Examine independent effects of maternal depression and personality disorder on infant care.	Between group comparison	Mothers with 2 month old infants, with a diagnosis of depression (n = 41), personality disorder (n = 39), both depression and personality disorder (n = 67), or neither (n = 53).	SAPAS, PHQ-9, SCID-II, socio-demographic schedule, SCID-I NP, structured interview, ITSEA (plus supplement for impoverished families), CARE-Index, NBAS	Women with a diagnosis of personality disorder more likely to be single, and more likely to have delivered their first baby. Significant independent detrimental effects of depression and personality disorder on infant care practices and maternal involvement with baby. Interaction effects of personality	94%

					disorder and depression. No moderating effect of infant irritability. Cluster A (DSM-IV: APA, 2013) interaction with depression on maternal sensitivity.	
Conroy et al (2012) UK	Examine associations between maternal personality disorder diagnosis, depression and adverse developmental outcomes in infants at 18 months old	Longitudinal, within group and between group	Women with newly delivered infants, with a diagnosis of depression (n = 41), personality disorder (n = 39), both depression and personality disorder (n = 67), or neither (n = 53).	Maternal: PHQ-9, SAPAS, CARE-Index, SCID-I (non-patient version). Infant: ITSEA, Mental Development Index of BSID-II.	Most prevalent personality disorders: obsessive-compulsive (19%), avoidant (18%), paranoid (17%) and borderline (17%). Women with a diagnosis of personality disorder more likely to be single. Infants of mothers with a diagnosis of personality disorder: higher dysregulation, internalisation and externalisation. Independent association of personality disorder on infant dysregulation and on infant cognitive outcome (BSID-II). Interaction between depression and personality disorder: detrimental effects on infant dysregulation only if both present.	100%

Cordes et al (2017) Denmark	Evaluate reflective functioning ('RF') in women with symptoms of PND, women with comorbid PND and personality disorder, and a non-clinical group	Between group, evaluation	Non-clinical group (n = 52), voluntary sample. Clinical group (n = 13 in PND group, n = 14 in PND and personality disorder group) were referred by health visitors after routine screening (EPDS), 8 weeks postpartum.	SCID-II, AAI (and reflective functioning scale applied to it). Screening: EPDS, PSE, diagnostic interviews.	No significant overall differences found in RF. Higher educational levels associated with higher RF scores in comorbid group. No correlation between RF and number of symptoms of personality disorder. 97%
Hudson et al (2017) Australia	Investigate whether women with a preconception diagnosis of personality disorder have increased rates of antenatal anxiety and/or depressive symptoms	Longitudinal within group	Pregnant women, aged 24-35, n = 244	Standardised Assessment of Personality, GHQ-12, Clinical Interview Schedule - Revised, EPDS	Preconception personality disorder associated with 3x likelihood of antenatal anxiety after adjustment for background factors. Preconception personality disorder associated with 2x likelihood of antenatal depression, however this was attenuated by background factors. 17.2% of women categorised as having a preconception personality disorder. 87%
Lucarina et al (2017) Italy	Determine which personality disorder traits can be found in women with	Between groups	Women recruited at obstetrics & gynaecology units, n = 54	EPDS, MMPI-II	APD associated with high scores on hypomania, cynicism and antisocial subscales (MMPI-2). PND (early onset - 1 week) 80%

	antepartum depression ('APD') and postnatal depression compared to women without perinatal depression.				associated with high scores on paranoia and low self-esteem subscales (MMPI-2). PND (late onset - up to 3 months) associated with high scores on fears, obsessiveness and depression subscales (MMPI-2).	
Newman, Stevenson, Bergman & Boyce (2007) Australia	Compare mothers with and without a diagnosis of borderline personality disorder in perinatal period - comparing mother-infant interaction and mother's self-perceptions of parenting	Between group comparison study	Mother-infant dyads (mothers with a diagnosis of borderline personality disorder), n = 17 Control group, n = 21	EPDS, SCL-90-R, PSCS, PSI-SF, and a 10 minute video recording of free play interaction (coded blind)	Mothers with a diagnosis of borderline personality disorder: less maternal sensitivity, less structure in interactions with infants. Self-report being less satisfied / competent and more distressed. Infants of mothers with a diagnosis of borderline personality disorder: less attentive, less interested, less eager to interact. Mothers with a diagnosis of borderline personality disorder: significantly more likely to be single; significantly lower annual household income.	87%
Ramsauer, Muhlhan, Mueller &	Compare parenting stress in depression and/or	Matched pairs between group	Mother-infant dyads at outpatient psychiatric medical centre. Split	SCID-I, BDI, SCL-90-R, PSI	Mothers with a diagnosis of borderline personality disorder: significantly lower household	77%

| Schulte-Markwort, (2015) Germany | anxiety sample with and without a diagnosis of personality disorder | comparison study | into groups: no personality disorder (n = 40), borderline personality disorder (n = 22), other personality disorder (n = 29). Children aged 2-11 months. Matched to control for axis-1 comorbidity. Some excluded because no match (91 down to 54). | | income. Tendency towards more education in mothers without a diagnosis of personality disorder than without. No other significant demographic differences. Mothers with a diagnosis of personality disorder: clinically significant BDI scores, self-reported significantly less competent than mothers without a diagnosis pf personality disorder, tended to rate their children as less positively reinforcing. Mothers with a diagnosis of borderline personality disorder: feel more isolated, experienced more conflict and less support from romantic partners. Other associations between personality disorder and PSI subscales: distractibility, role restriction, health, parent domain and total stress. Borderline personality disorder associated with attachment. | |
| Smith-Nielson et al | Examine whether mothers with PND | Between group | Clinical group mothers referred following | EPDS, SCID-II, PSE, AAI | Correlation between high EPDS score and personality pathology. | 90% |

(2015) Denmark	symptoms showed higher levels of personality pathology and more insecure attachment, compared to non-depressed mothers.	comparison study	clinical score on EPDS during routine screening 8 weeks postpartum, n = 30. Comparison group drawn from wider study, n = 55		Personality disorder and AAI classification independently related to EPDS score (together accounting for 48% of variance)
Uguz, Akman, Sahingoz, Kaya & Kucur (2008) Turkey	Increase understanding of long-term follow-up and risk factors of persistent PND in less developed country	Between group comparison study; longitudinal (1 year follow up)	Women with diagnosis of new-onset depression during 6 weeks postpartum. Personality disorder diagnosis: n = 14. No personality disorder diagnosis: n = 20.	EPDS, SCID-I	Rate of PND at follow-up related to diagnosis of axis 2 disorder, especially personality disorder; specifically avoidant, dependent and obsessive-compulsive. 71% of women with a diagnosis of personality disorder were depressed at follow-up, compared to 5% without. 81%

Abbreviations legend: AAI: Adult Attachment Interview; APD: ante-partum depression; BDI: Beck Depression Inventory; BSID-II: Bayley Scales of Infant Development II; DSM-IV: Diagnostic and Statistical Manual of Mental Disorders IV; EPDS: Edinburgh Postnatal Depression Scale; GHQ-12: General Health Questionnaire (12 items);: HOME: Home Observation for Measurement of the Environment; ITSEA: Infant-Toddler Social and Emotional Assessment; MMPI-II: Minnesota Multiphasic Personality Inventory II; NBAS: Neonatal Behavioural Assessment Scale; PHQ-9: Patient Health Questionnaire (9 items); PND: post-natal depression; PSCS: Parenting Sense of Competence Scale; PSE: Present State Examination; PSI: Parenting Stress Index; PSI-SF: Parenting Stress Index, Short Form; SAPAS: Standardised Assessment of

Personality - Abbreviated Scale; SCID-I: Structured Clinical Interview for DSM-IV Axis I Disorders (NP: non-patient version); SCID-II:

Structured Clinical Interview for DSM-IV Axis II Disorders; SCL-90: Symptom Checklist (90 items) (R: revised); RF: reflective functioning.

Methodological quality

The included articles received quality rating scores ranging from 77 - 97% (see Appendix D). The mean score was 88%. All articles provided clear rationales for their research and showed adequate quality in the reporting of their findings and discussion of implications. The main problematic area in included articles was considering and accounting for bias, and consideration of ethical issues in either the procedure of the article or the implications of the article's findings. Additionally, 4 studies used samples that may not have been representative of the target population from which they recruited (Lucarina et al, 2015; Ramsauer, Muhlhan, Mueller & Schulte-Markwort, 2015; Smith-Nielson et al, 2015; Uguz, Akman, Sahingoz, Kaya & Kucur, 2008).

Measures

Measures most frequently used by the included studies were the Structured Clinical Interview for DSM-IV Axis II Disorders (SCID-II; First & Gibbon, 2004), Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I; First & Gibbon, 2004), the Edinburgh Postnatal Depression Scale (EPDS; Cox, Holden & Sagovsky, 1987), and the Standardised Assessment of Personality – Abbreviated Scale (SAPAS; Moran et al, 2003). However a variety of measures were used across the studies, and the studies all measured different outcomes, and therefore used different measures appropriate for these outcomes.

Synthesis

Cohort demographics.

Five articles collected data regarding the specific demographic characteristics of mothers with a diagnosis of personality disorder. However, two of these were studies that used the same sample of participants, therefore for the purposes of this section of analysis they are treated as one group in terms of representative demographics (Conroy, Marks, Schacht, Davies & Moran, 2009; Conroy et al, 2012). Of the remaining four, one article compared characteristics of mothers with and without a diagnosis of personality disorder in general (Conroy et al, 2009 / 2012), and two focused on borderline personality disorder in particular (Blankley, Galbally, Snellen, Power and Lewis, 2015; Newman, Stevenson, Bergman and Boyce, 2007). Ramsauer et al (2015) included groups of both borderline personality disorder and 'other personality disorder'. Three of the four articles also included mothers with comorbid perinatal mental health problems in their sample (Conroy et al, 2009 / 2012; Newman et al, 2007; Ramsauer et al, 2015). All articles had non-clinical comparison groups, and all articles except Blankley et al's used statistical analysis to examine differences between groups.

Conroy et al (2009 / 2012) and Newman et al (2007) both found a significant association between personality disorder diagnosis and being single. While Newman et al's sample was relatively small and therefore this finding could be regarded as unreliable alone, the support from Conroy et al's larger sample marks this as a more reliable finding. Newman et al (2007) also found household annual income to be significantly lower in mothers with a diagnosis of borderline personality disorder than mothers without, as did Ramsauer et al (2015). However, Ramsauer et al's sample was also small and is not considered to be representative of the wider population from which it was drawn. Therefore this finding should be considered tentative and may be better explained by other factors.

Another main finding is that mothers with a diagnosis of borderline personality disorder reported feeling significantly more isolated, and experienced more conflict and less support from their spouses or romantic partners (Ramsauer et al, 2015). This is congruent with findings from Blankley et al (2015) that mothers with a diagnosis of borderline personality disorder experience considerable psychosocial impairment. This could be considered a risk factor for experiencing psychological distress during the perinatal period. However this finding should also be considered tentative due to sampling issues in Ramsauer et al's study and the fact that Blankley et al's study did not use statistical testing to establish differences between the demographics of the borderline personality disorder group and a control.

A tendency towards less education in mothers with a diagnosis of personality disorder than mothers without was noted by Ramsauer et al (2015), however this did not reach statistical significance and requires further investigation before it can be considered a characteristic of this population.

Conroy et al (2009) identified that women with a diagnosis of personality disorder within the clinical sample were more likely to be delivering their first baby, suggesting that women with a diagnosis of personality disorder are particularly susceptible to perinatal mental health problems and subsequent referral to mental health services around the birth of their first child as opposed to any additional children.

Additional factors relating specifically to borderline personality disorder recorded by Blankley et al (2015) included: anticipating birth as traumatic and frequently requesting early delivery, high comorbidity with substance abuse, and high rate of referral to child protection services. These factors lend weight to the notion that mothers with a diagnosis of personality disorder, particularly borderline personality disorder, are an at-risk group who require more support in a variety of areas during the perinatal period - not just perinatal mental health.

It should also be clarified that no other sociodemographic differences were found beyond those stated here (Blankley et al, 2007; Conroy et al, 2009 / 2012; Newman et al, 2007; Ramsauer et al, 2015).

Impact of maternal personality disorder and perinatal mental health problems on the infant.

Three articles investigated outcomes relating to the impact of maternal personality disorder on the infant (Blankley et al, 2015; Newman et al, 2007; Conroy et al, 2012). One considered medical outcomes such as APGAR scores at birth, prematurity, and referral to special care nurseries, and social outcomes such as referral to child protective services (Blankley et al, 2015). The other articles considered more psychological effects. Conroy et al (2012) looked at emotional dysregulation, internalisation, externalisation and cognitive outcome. Newman et al (2007) investigated infant responsiveness and involvement. None of the articles investigated the same outcomes, therefore it was not possible to directly compare or collate scores. All articles scored highly on the quality assessment checklist (87 - 100%) and the main shortcomings were related to discussion of ethical issues within the paper, and consideration of bias.

Blankley et al (2015) found that infants of mothers with a diagnosis of borderline personality disorder were more likely to have significantly more negative birth outcomes than infants of mothers without a diagnosis of borderline personality disorder. Medical outcomes included lower Apgar scores (25% below 7 compared to 12.5%), prematurity (21% born before 37 weeks compared to 10%), referral to special nursery care (33% compared to 16%) and need for resuscitation (28% compared to 17%). Additionally, a trend towards lower birth weight was found (19% below 2500g

compared to 8%), however this did not reach statistical significance. Infants were also significantly more likely to be considered at risk in terms of the context around them, as reflected by a higher referral rate to child protective services (52% compared to 0.9%) and family support services (33% compared to 0.4%). Blankley et al considered that their sample may not be representative of all pregnant women with a diagnosis of borderline personality disorder, as the women in the study are only those who require support from services. However, their sample was recruited from obstetric services as opposed to mothers referred for further treatment, suggesting that their sample is representative of women presenting for maternity care, thus excluding only women giving birth at home.

Conroy et al (2012) found significant effects of maternal personality disorder diagnosis on infant dysregulation (negative emotionality, sleep, eating, sensory sensitivity), internalising behaviours (depression / withdrawal, separation distress, anxiety, inhibition to novelty) and externalising behaviours (activity / impulsivity, aggression / defiance, peer aggression). They did not find significant effects on infant competence (compliance, attention, mastery motivation, imitation / play, empathy, prosocial peer relations). Additionally, no effect of maternal personality disorder diagnosis was found on infant cognitive development at 18 months (as measured by the Bayley mental scale) in a univariate analysis, however a multivariate analysis returned a significant effect. Conroy et al recommend interpreting this with caution as it may represent a type 1 error. Additionally, as the measure used (Infant-Toddler Social and Emotional Assessment; 'ITSEA') is a parental self-report measure, findings should be considered in light of the fact that parental depression may account for some differences in reported infant outcomes.

Finally, Newman et al (2007) considered infant outcomes relating to the mother-infant relationship such as infant responsiveness and infant involvement. Infants (aged 3

– 36 months) of mothers with a diagnosis of borderline personality disorder scored significantly lower than those in the control group on both outcomes. These outcomes were measured using the Emotional Availability scale to assess 10 minute videos of free play between mother and child. This is rated by an observer rather than the mother, therefore the study is not as susceptible to bias as Conroy et al's.

Effects of personality disorders during the perinatal period on the mothers.

Five articles looked at outcomes relating to the impact of personality disorder in the perinatal period on the mother (Blankley et al, 2015; Hudson et al, 2017; Newman et al, 2007; Ramsauer et al, 2015; Smith-Nielson et al, 2015). All articles had acceptable quality assessment ratings (77 - 90%). Common shortcomings of articles related to appropriate sampling, lack of consideration of bias and ethical issues, and inadequate reporting within the articles of design and outcomes, though this may be attributed to the write up as opposed to a flaw in the methodology of the study. Mental health outcomes were included in this section with the exception of depression, as this will be discussed in further depth in the next section.

Interpersonal and social outcomes.

Blankley et al (2015) found that mothers with a diagnosis of borderline personality disorder had considerable psychosocial impairment as identified by a retrospective case review, with higher rates of referral to family services, and higher rates of substance misuse. These findings were significant as compared to a control group of mothers without a diagnosis of borderline personality disorder. Ramsauer et al (2015) found that mothers with a diagnosis of borderline personality disorder reported feeling more isolated, and experienced more conflict and less support within current

romantic relationships. These findings were significant as compared to a control group of mothers without a diagnosis of personality disorder. Ramsauer et al did not find any significant interpersonal or social effects on mothers with a diagnosis of personality disorder other than borderline personality disorder, suggesting that this is a difficulty specific to borderline personality disorder.

Ability to interact appropriately with infant, and perceptions of mothering ability.

Two articles investigated outcomes regarding the relationship between mother and infant, including the mother's perceptions of their own ability to mother the infant. Newman et al (2007) reported that mothers with a diagnosis of borderline personality disorder showed significantly less maternal sensitivity and provided less structure in their interactions with their infants than mothers without a diagnosis of borderline personality disorder, however their sample was too small to generalise these findings to all mothers with a diagnosis of borderline personality disorder. They also found that mothers with a diagnosis of borderline personality disorder reported themselves to feel significantly less satisfied, less competent and more distressed than mothers without a diagnosis of borderline personality disorder. Ramsauer et al (2015) also found that mothers with a diagnosis of borderline personality disorder reported feeling less competent, reinforcing this finding and suggesting that it may be generalizable and again specific to personality disorder rather than other personality disorders.

Mental health (except depression, which will be discussed below).

The impact of personality disorder on the mother's mental health during the perinatal period was discussed by 4 papers (Blankley et al, 2015; Hudson et al, 2017;

Ramsauer et al, 2015; Smith-Nielson et al, 2015). Blankley et al (2015) reported that mothers with a diagnosis of borderline personality disorder anticipate birth as traumatic and as a result frequently request early delivery. Hudson et al (2015)'s findings that mothers with a diagnosis of personality disorder are three times more likely to show signs of antenatal anxiety than mothers without a diagnosis of personality disorder; congruent with Blankley et al's findings. After birth, parenting stress was found to be significantly higher by Ramsauer et al (2015), suggesting that this state of heightened emotionality continues into the postnatal period. Ramsauer et al found that mothers with a diagnosis of personality disorder scored higher on most subscales of a parenting stress measure, including total stress. They also found that mothers with a diagnosis of borderline personality disorder specifically scored highest on the attachment subscale. Smith-Nielson et al (2015) found no association between personality disorder diagnosis and attachment, however their sample did not include any individuals with Cluster B (DSM-IV: APA, 2013) personality disorders, which is the cluster to which borderline personality disorder belongs.

Postnatal depression and personality disorder comorbidity and interaction.

Seven studies considered the comorbidity effects of postnatal depression and personality disorder (Apter, Devouche, Gratier, Valente and Le Nestour, 2012; Conroy et al, 2009; Hudson et al, 2017; Lucarina et al, 2017; Ramsauer et al, 2015; Smith-Nielson et al, 2015; Uguz et al, 2008).

Five of the seven studies measured the rate of comorbidity, however all did so in different ways. Apter et al (2012) reported that 60% of depressed mothers met the criteria for a personality disorder, compared to 30% of non-depressed mothers. Hudson et al (2017) reported that preconception personality disorder diagnosis was associated

with double odds of antenatal depressive symptoms, though this was attenuated for by other preconception background factors including income, parental divorce and mental disorders. Ramsauer et al (2015) found that in their sample mothers with a diagnosis of personality disorder reported on average clinically significant Beck Depression Inventory (BDI; Beck & Steer, 1987) scores, suggesting a high likelihood of depression (Beck & Steer, 1987) and as their infants were between 2 and 11 months this is considered to be perinatal. Smith-Nielson et al (2015) found a significant association between high EPDS scores and personality disorder diagnosis, with mothers above clinical cut-off more likely to have a diagnosis of personality disorder than mothers below. Uguz et al (2008) found that 71% of women with a diagnosis of personality disorder were depressed at follow-up (1 year and 6 weeks after birth) compared to 5% of women without, however this is from a sample of women who all had PND at 6 weeks after birth, and at follow-up they were technically outside the NICE definition of the perinatal period. However, such a wide margin can be considered to imply that mothers with a diagnosis of personality disorder were also more likely to have been depressed 6 weeks prior to the follow-up date. Taken together these findings clearly show an association between PND and depression, however the direction of this association is unclear; there is no evidence to suggest that personality disorder is the cause of PND, or vice versa.

Two studies considered which cluster (DSM-IV: APA, 2013) or personality disorder type was most strongly associated with PND. Apter et al (2012) found that Cluster B personality disorders, particularly borderline personality disorder, were most strongly associated, and that women with avoidant and paranoid personality disorders were also strongly associated. Of the women in their sample, women with diagnoses of these personality disorders were more often depressed than not. Uguz et al (2008) found that avoidant, dependent and obsessive-compulsive personality disorders were most

related to rate of PND at follow-up; again, this suffers the above criticism that their follow-up was outside the NICE defined perinatal period. Additionally, all three personality disorder types identified by Uguz et al belong to Cluster C, which is known as the anxious cluster and is associated with Generalised Anxiety Disorder (APA, 2013). Therefore a part of the association may be accounted for by the known comorbidity rates of anxiety and depression in the general population (Tiller, 2013), which has been corroborated in the postpartum period (Reck et al, 2008). Overall these findings suggest that personality disorder requires further investigation as a risk factor for PND.

Lucarina et al (2017) looked not at diagnosis of personality disorder but particular traits of personality disorder using the Minnesota Multiphasic Personality Inventory 2, and found that antenatal depression is related to high scores on hypomania, cynicism and antisocial practice; early onset (first week) postnatal depression is associated with high scores on paranoia and low self-esteem; late onset (up to three months) postnatal depression is associated with high scores on fears, obsessiveness and depression subscales.

Not only do PND and personality disorder appear to occur comorbidly, but two studies suggest that their effects are interlinked. Conroy et al (2009) and Conroy et al (2012) investigated interaction effects of PND and personality disorder and found that when women had a diagnosis of personality disorder, PND had an effect on infant care practice, but when women did not have a diagnosis of personality disorder, PND had no effect. The inverse was also found whereby if women had PND, personality disorder diagnosis had an effect on infant care practice, and when women did not have a diagnosis of personality disorder, PND had no effect (Conroy et al, 2009). Additionally, Cluster A (DSM-IV: APA, 2013) personality disorders showed a similar interaction effect on maternal sensitivity, however this was not found for other clusters of

personality disorder s. Conroy et al (2012) also found interaction effects between PND and personality disorder diagnosis on infant dysregulation.

Discussion

This review aimed to synthesise the current research into personality disorders in the perinatal period. The key findings were that women with a diagnosis of personality disorder suffer from perinatal mental health problems such as depression, anxiety and parenting-related stress more frequently and more severely than mothers without a diagnosis of personality disorder. Borderline personality disorder was particularly heavily implicated in depression and also impacted on mothers' confidence in their parenting abilities. Mothers with a diagnosis of personality disorder also appeared to have links to specific demographic factors: being single and having a low annual household income; and for borderline personality disorder specifically: being isolated and receiving less support from current romantic partners. Finally, perhaps as a result of the above factors, infants of mothers with a diagnosis of personality disorder were reported to have shown higher levels of emotional dysregulation, and infants of mothers with borderline personality disorder specifically had poorer birth outcomes (such as lower Apgar scores, prematurity) and showed less responsiveness and involvement in the relationship with their mother.

Some of these factors may be linked, for example being single resulting in only having one source of household income, and the cost of living being higher for individuals who are single (Davis et al, 2012). A lack of supportive social relationships combined with social stressors such as financial worries (Stack & Meredith, 2018) could explain the increased likelihood of prenatal anxiety and anticipation of birth as a traumatic event. Women with a diagnosis of personality disorder may be particularly

susceptible to these stressors, in line with the diathesis-stress model of personality disorders (Paris, 1999). Additionally, historic trauma (which is known to be more frequent in individuals with a diagnosis of personality disorder than in the general population; Polusny & Follette, 1995; Johnson, Smailes, Cohen, Brown, & Bernstein, 2000) may contribute to increased anxieties and fear of further traumatic experiences. Services should consider the support networks available to women with diagnoses of personality disorder and endeavour to build up the resources available to them during pregnancy, so that they are better supported once it comes to birth and the postpartum. These factors have also been implicated in perinatal mental health problems in a perinatal population without personality disorder diagnosis (Fisher et al, 2012; Milgrom et al, 2007) and so are valid intervention points irrespective of personality disorder diagnosis.

The association between maternal borderline personality disorder diagnosis specifically and social and relational deficits makes sense in the context of the defining features of borderline personality disorder, which are difficulties in relationships to others and poor emotional processing and coping strategies (Levine, Marziali & Hood, 1997). A high stress time such as the perinatal period provides difficulties for any woman, which requires good emotional coping strategies. There is the additional challenge of relating to a new infant, as well as relating to those around for support. The lack of strong relationships and wider support networks as a result of social and relational deficits makes women with personality disorder diagnoses particularly vulnerable and in need of greater support. If stigma then provides a further barrier to seeking out or receiving support (Hadfield & Wittkowski, 2017; Staneva, Bogossian & Wittkowski, 2015), then stigma must be addressed by research and by perinatal mental health services to find ways to support these women. Additionally, if personality disorder is understood in terms of a trauma model, it should be understood that some

women may struggle to trust and accept support from services as it may feel inherently threatening or retraumatising (Kezelman & Stavropoulos, 2012).

However, there is a possibility for the perinatal period being a time of growth for mothers with borderline personality disorder, as they may find a sense of identity, belonging and a support network through the 'motherhood club' and connect more strongly with their families and communities (Carin, Lundgren & Bergbom, 2011). Belonging has been shown to be an important factor in mental health (Hagerty, Lynch-Sauer, Patusky, Bouwsema & Collier, 1992). It is noteworthy that positive factors such as belonging have not been investigated in the articles in this review. This may reflect a trend for research to focus on negative factors (Sheldon & King, 2001), with a view to fixing or removing them. It may be beneficial for future research to include positive factors such as belonging in order to improve emotional wellbeing and quality of life.

As well as considering the positives, the assumption that personality disorder is the root cause of difficulties during the peripartum should also be examined. If having a diagnosis of personality disorder results in an increased likelihood of experiencing social disadvantage such as low annual household income, this social disadvantage may be what is responsible for the increased likelihood of mental health problems. This idea is supported by evidence that social disadvantage is strongly associated with increased rates of depression and anxiety in both the general population (Fryers, Melzer & Jenkins, 2003) and perinatal populations (Reading & Reynolds, 2001). Additionally, this may represent a reciprocal relationship, as mental health problems and the societal stigma around them can exacerbate social problems (Tew et al, 2012). This reinforces the need for a holistic, non-judgemental approach to working with this client group during the peripartum instead of or as well as intervening specifically around the personality disorder traits, as if social needs are neglected these women will remain vulnerable.

The effects of this reciprocal relationship are not limited to the mother. There are theories surrounding the emotional and behavioural impact on the infant relating to a transgenerational effect of personality disorder traits, borderline personality disorder in particular (White, Gunderson, Zanarini & Hudson, 2003). This theory suggests that personality disorder traits affect a mother's ability to teach her child strong and flexible emotional coping strategies, thus leading the child to exhibit symptoms of personality disorder themselves, which may in turn affect their own children. The lack of longitudinal studies relating to personality disorder means this theory is not yet backed up by a strong evidence base, but perinatal mental health staff have identified these patterns within services (Steele, 2018). This theory cannot explain the impact that maternal personality disorder diagnosis has on physical birth outcomes, however it is possible to hypothesise that there are similar processes occurring to those taking place in perinatal anxiety and depression, which have been associated with low birth weight, low Neonatal Behavioural Assessment Scale scores, and lower infant cardiac vagal tone (Alder, Fink, Bitzer, Hosli & Holzgreve, 2007). This is an area which requires further investigation to establish possible underlying mechanisms.

The comorbidity between personality disorder diagnosis and PND could be interpreted as providing evidence that the two are not distinct diagnoses, however this requires further research. Personality disorder traits are known to be associated with depression in the general population (Newton-Howes, Tyrer & Johnson, 2006), and studies have highlighted similar outcomes for mothers with PND to those in this review (Field, Diego & Hernandez-Reif, 2006; Murray, Fiori-Cowley, Hooper & Cooper, 1996; Grace, Evindar & Stewart, 2003). The interaction effects identified in this review could therefore be understood in terms of an overlap between the diagnoses of personality disorder and PND, or misdiagnosis of one as the other.

Limitations

The use of self-report to measure maternal outcomes may have introduced bias into the results. Individuals experiencing depression are known to experience negative biases that may cause them to interpret their symptoms more severely than someone objectively rating them. This may have caused false significance within PND groups.

Many of the studies used screening measures to assess traits of personality disorder, such as the Standardised Assessment of Personality (Abbreviated Scale; 'SAPAS'; Moran et al, 2003). The SAPAS is generally accepted to have sufficient validity to screen for personality disorder traits as compared to more extensive measures (Hesse & Moran, 2010), however studies frequently assessed women for personality disorder traits during the perinatal period or when they had been identified as experiencing mental health problems. This introduces an added layer of complexity into the diagnosis and undermines the validity of the comparative element of the studies. The SAPAS has not been validated in a perinatal population.

An issue of this review is the heterogeneity of studies and of measures used. This has made comparing findings complex, as measures may not measure the same thing or may have operationalised constructs differently. Additionally, the measures used may vary in validity and reliability. However the range of measures may be reflective of the breadth of the definitions of personality disorder and of the broad spectrum of possible perinatal mental illnesses, as well as the range of outcomes that may be affected. This reinforces literature criticising the use of 'personality disorder' as an umbrella term. Nonetheless, this review may illuminate specific areas in which women who have a presentation consistent with this diagnosis can be better supported, whether or not the overall diagnostic label is considered to be valid.

Implications for research and practice

The findings identified in this review provide important information for staff working within perinatal mental health services, for researchers investigating personality disorder and the perinatal period, and for individuals experiencing difficulties. This review identifies individuals who may be particularly at risk, areas for preventative intervention, areas for intervention, and topics requiring further research.

As well as needing the skills to care for women with diagnoses of personality disorder (i.e. familiarity with concepts from specialised therapies such as Dialectical Behaviour Therapy (Linehan, 1987) or models such as trauma-informed care (Hodas, 2006)), staff in perinatal services should be particularly aware of the risk of increased likelihood and/or severity of perinatal mental health problems if women with diagnoses of personality disorder are single, experiencing social isolation, have a low annual income, and/or are experiencing marital conflict. Use of Maslow's Hierarchy of Needs model (1943) or Bronfenbrenner's Ecological Systems model (1994) could facilitate more in-depth global formulation beyond individual factors. Becoming more aware of these risk factors may enable earlier identification and preventative intervention for women in need of additional support during the perinatal period. Early intervention can prevent the progression of mental illness, reducing the likelihood of adverse consequences (Eisenberg, Speer & Hunt, 2012). Other preventative interventions identified by this review include support if mothers are anticipating the birth as a traumatic event, and self-esteem and education interventions to support mothers to feel they are effective in caring for and bonding with their baby. It also identifies some obstetric considerations that professionals should be aware of, i.e. low birth weight, low Apgar score, prematurity and need for resuscitation.

Current interventions recommended by NICE guidelines focus on stabilisation of mental health problems, and cognitive behavioural or supportive counselling or

group approaches for issues such as depression or tokophobia (fear of childbirth; NICE, 2016). They also recommend interventions to improve the relationship between mother and baby if issues are identified. This review's findings support the use of these interventions for mothers with personality disorder diagnoses, and additionally identifies a need for ongoing support in social matters. Clinical Psychology could contribute by providing specialist training to mental health staff in working with the attachment relationship, in supporting staff to consider the context around women's mental health problems through reflective practice or supervision, and in providing specialised interventions for women with personality disorders such as Dialectical Behaviour Therapy for borderline personality disorder (Linehan, 1987) to promote emotional wellbeing.

This review identifies a need for future research into personality disorder in the perinatal period to be more consistent in order to build up a body of literature that can be compared. It also needs to be more robust in terms of measures used to measure maternal outcomes, considering the impact of negative biases on self-report measures. A focus for future research is the validity of distinguishing between diagnoses of personality disorder and PND, and further investigating the comorbidity effects.

Conclusion

Overall, the literature suggests that personality disorder diagnosis is associated with poorer birth outcomes and later cognitive and emotional development for the infant, and has associations with social disadvantage and poorer mental health for the mother. However, these outcomes may not be directly attributable to personality disorder diagnosis; the comorbidity between personality disorder diagnosis and PND should be considered, as they represent many similar symptoms and are associated with

a lot of the same outcomes. There did not appear to be any significant contradictions in the findings of the studies reviewed, but this may be attributed to the heterogeneity of the measures and outcomes used. Finally, it should be held in mind that the social disadvantage and stigma that women with personality disorder diagnoses may experience may be keeping them trapped in a cycle of poor mental health, and intervention plans should therefore acknowledge social factors and take a non-judgemental approach.

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Part Two: Empirical Paper

This paper is written in the format ready for submission to the

Infant Mental Health Journal

Please see Appendix A for the submission guidelines

"This is not just about a baby in a womb": a Thematic Analysis of Staff Views of Perinatal Mental Health

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Abstract

Aims: This study aimed to explore the themes evident in staff discussion of perinatal mental wellbeing, perinatal mental health problems, and perinatal mental health care; to explore how staff understand perinatal mental health problems; and to explore how staff's understanding of perinatal mental illness impacts on practice.

Method: Semi-structured focus groups were conducted with 18 participants. Thematic analysis was used to analyse the data.

Results: Six superordinate themes were identified: Mother's Context, Service Context, Ways of Practising, Professional's Qualities, Risk, and Mismatch.

Conclusions: Staff highlighted the importance of holistic care that acknowledges women as more than just a 'vessel for their baby', and specialist services that have the resources to provide this care. Care also needed to be person-centred and able to work with social issues such as financial disadvantage or stigma associated with mental health problems. Preventative intervention was also considered an important aspect of care. There appeared to be a tension between the care staff wanted to provide and the care they were able to provide as a result of service constraints. The results of this study have implications for future service development.

Keywords: perinatal mental health, mental health care, maternal mental health, service development, thematic analysis

"This is not just about a baby in a womb": a Thematic Analysis of Staff Views of

Perinatal Mental Health

The perinatal period is defined by the National Institute for Health and Clinical

Excellence ('NICE') guidance as pregnancy and the first year after a baby's birth (NICE,

2016). During this period, an average of 10% of women are affected by mental illness

(Hogg, 2013), henceforth 'perinatal mental health problems'. This can range from the

'baby blues', defined as a period of mild low mood of up to two weeks and experienced

by up to 84% of women (O'Hara & Wisner, 2014), to severe mental illness such as

puerperal psychosis, which can display as a sudden onset psychotic episode with severe

potential consequences such as suicide and infanticide if left untreated (Khan, Wojdyla,

Say, Gülmezoglu & Van Look, 2006; O'Hara & Wisner, 2014; Manktelow et al, 2016).

Perinatal mental health problems present an immediate risk to the mother and infant and

risk of long term emotional consequences for the child, with increased risk of

psychiatric behavioural, social and learning difficulties (Manning & Gregoire, 2009;

O'Donnell, Glover, Barker & O'Connor, 2014).

The high level of risk associated with perinatal mental health problems has led

to multiple reports exploring current provision of services and the need for expansion

(Hogg, 2013; Boots Family Alliance, 2013). A recent meta-synthesis exploring mothers'

experiences of perinatal mental health problems suggests that a more psychological

approach to their understanding and treatment is desired (Megnin-Viggars, Symington,

Howard & Pilling, 2015), with mothers' experiences of perinatal mental health care as

unsatisfactory and predominantly biomedical, focusing on pharmacological treatments

as a first port of call. A qualitative synthesis focusing specifically on experiences of

psychological and psychosocial interventions found these were considered to be

beneficial (Hadfield & Wittkowski, 2015), and a randomized controlled trial of

psychological interventions for postnatal depression found them to be superior to

routine care (Milgrom, Negri, Gemmill, McNeil & Martin, 2005). Psychological and psychosocial factors such as stigma, focus on babies over mothers, lack of social support, personality, stressful life events, lack of sleep and pressure are considered to contribute to the development and maintenance of perinatal mental health problems (Boots Family Alliance, 2013; Megnin-Viggars et al, 2015). These findings are in line with a previous meta-synthesis (Robertson, Grace, Wallington & Stewart, 2004). The most recent NICE recommendations have included psychological and psychosocial interventions, in addition to recommendations of pharmacological intervention (NICE, 2014a).

In the wider field of mental health a paradigm shift has been observed from understanding mental illness in terms of biological and medical issues to understanding it as a combination of psychological, cultural and social factors in addition to possible biological and medical problems (Fee, 1999). This shift can be observed in the discourses surrounding psychosis, which have shifted from biomedical to biopsychosocial (Bentall, 2004). As societal discourses have changed, so have treatment recommendations, with current recommendations including psychosocial interventions such as psychological therapies and community interventions being recommended in addition to or instead of the previously predominant pharmacological interventions (NICE, 2014b). However women's experiences suggest that current understanding of perinatal mental health problems in services is primarily biomedical (Megnin-Viggars et al, 2015).

Postnatal depression (PND) in particular had until recently been understood in terms of hormonal imbalances (O'Hara & Wisner, 2014; Soares & Zitek, 2008) and treatment recommendations had reflected this, recommending pharmacological intervention to correct the imbalance (NICE, 2007). However, recent literature has provided an alternative, more psychological understanding of PND which has resulted

in increasing use of psychosocial interventions (O'Hara & Wisner, 2014). Reports of mothers' experiences suggest that this change has been limited to PND and has not extended to other perinatal mental health problems such as puerperal psychosis, anxiety or OCD (Megnin-Viggars et al, 2015). While NICE guidance may reflect the beginning of a shift towards a psychosocial understanding of perinatal mental health problems, mother's experiences of care suggests that service provision is yet to catch up. This slow progression compared to other fields in mental illness (Bentall, 2004; Megnin-Viggars et al, 2015) suggests that there may be factors such as service constraints or practice-based knowledge causing care to focus on pharmacology, as opposed to more rounded care incorporating psychological and psychosocial factors as well as biological.

In 2007, 4-5% of severe cases of perinatal mental health problems resulted in maternal suicide or infanticide (Heron, Blackmore, McGuinness, Craddock & Jones, 2007). Such severe consequences highlight the need to consider all possible treatment options; while treatment outcomes have improved in recent years, there appears to still be a need for significant improvement in the provision of perinatal mental health services.

The perceptions of staff may offer a vital insight into the current position of perinatal mental health services in terms of their understanding of the aetiology of perinatal mental health problems, and the most effective treatment options. Staff in wider perinatal services in 2010 felt there were difficulties in current care with follow-up and with liaison between the professionals involved in care, however the analysis did not cover staff understanding of perinatal mental health problems (Rowan, McCourt & Bick, 2010). Research has established that midwives and health visitors do not feel fully equipped to work with perinatal mental health problems (Hauck et al, 2015; Jomeen, Glover, Jones, Garg & Marshall, 2013), reflecting Megnin-Viggars et al's (2015) finding that women feel healthcare professionals are unable or unwilling to address their

psychological needs. Staff in specialist perinatal mental health services may be best positioned to provide practice-based knowledge on perinatal mental health problems, appropriate care, and service development.

This study therefore aims to examine perinatal mental health care in the United Kingdom (UK) from the perspective of staff within mental health teams, exploring the themes that arise in discussion of perinatal mental health problems. The findings of this study could have wide-ranging clinical significance as up to 1 in 5 women experience some kind of perinatal mental health problem (NICE, 2014a). NICE guidelines aim to provide optimal care for these women, however if NICE guidelines are not being implemented fully then it must be established what is preventing guidelines from being implemented, or how guidelines can be improved to be more appropriate for women. This study could provide evidence to support commissioning documentation to further develop services and support the development of specialist perinatal mental health services in localities which do not yet have them.

Primary aim

- To explore the themes evident in staff discussion of perinatal mental wellbeing, perinatal mental health problems, and perinatal mental health care.

Secondary aims

- To explore how staff understand perinatal mental health problems.
- To explore how staff's understanding of perinatal mental illness impacts on practice.

Method

Design

This qualitative study used semi-structured focus groups to explore the themes that arose when perinatal mental health staff discussed perinatal mental health problems and care. The focus groups were transcribed and analysed using an inductive Thematic Analysis (Braun & Clarke, 2006) to identify themes within the data. The researcher's epistemological stance is presented in Appendix E.

A qualitative analysis was selected to allow for an in-depth exploration of the data, and to allow further issues to arise that the researcher had not previously considered. Thematic analysis was considered the most appropriate method of analysis because it allows for a 'curious', explorative stance, gaining a broad overview of the themes discussed (Braun & Clarke, 2006). Thematic analysis also allows for results to be grounded within the data (Denzin & Lincoln, 2005), thus accessing what staff know as opposed to what the researcher interpreted staff to know. Multiple layers of hermeneutics are therefore acknowledged (Smith, 2004) and some degree of interpretation may have occurred in the results. It could be argued that a triple hermeneutic was present, with the researcher interpreting the teams' interpretations of staffs members' individual interpretations.

Participants

Participants were recruited opportunistically from 3 NHS Foundation Trusts, two in the North of England and one in the South. Overall, 18 perinatal mental health staff participated in the research. To be eligible to take part, participants needed to be currently working or on placement with a perinatal mental health team or Mother and Baby Unit ('MBU'), be able to speak and understand English, and be willing to take part.

As data was gathered from a small pool of participants, demographic information will be reported in terms of the entire sample to ensure confidentiality and anonymity of participants and their data. Five of the 18 participants were male, and the majority of participants were specialist mental health nurses. Other professions represented included psychiatry, psychotherapy, social work, ward matron and student nurse. Participants had worked in perinatal mental health for between 3 days and 10 years (mean = 4 years), and for all but two participants this was their first post in perinatal mental health. The majority of staff worked in perinatal mental health community teams, and some worked in an MBU or in both and MBU and a community team.

Procedure

Ethical approval was granted by a local University Research Ethics Committee, and the Health Research Authority at the researcher's NHS Foundation Trust (Appendix F).

Managers of 8 perinatal mental health teams were contacted and asked to circulate information regarding the research to the team (Appendix G) so that staff could contact the researcher with any questions prior to the focus group. The researcher also attended one team's weekly meeting to discuss the research with staff prior to the focus group taking place.

Focus groups were used to capture a more ecologically valid representation of staff team's clinical care decisions than individual interviews would, as staff primarily worked within team settings rather than individually. This is in line with Krueger & Casey's recommendation of using focus groups when you want ideas to emerge from the group (2015). One focus group was conducted per team and participants were not mixed across the teams, in order to facilitate conversation and self-disclosure as teams

who are more familiar with each other are more likely to produce useful data (Onwuegbuzie, Dickinson, Leech & Zoran, 2009).

The researcher attended the departments of the teams to complete the focus groups at a mutually agreed time. Attendance at the focus group was not compulsory and participants were given time before the focus group began to read through the information sheets and ask the researcher questions. Information was given about anonymity and confidentiality and participants were asked to complete a written consent form (Appendix H), which was stored separately to participant data to ensure confidentiality.

All focus groups were audio recorded and lasted between 55 minutes and 1 hour and 18 minutes (mean = 1 hour 10 minutes). The focus groups were conducted using a semi-structured interview schedule whereby the researcher asked open questions around the topics based on what the participants discussed (please see Appendix I for examples of topics covered). The focus group schedule was developed in collaboration with one perinatal team and through discussion with co-workers experienced in qualitative research. The focus groups typically began with the researcher reiterating the key points from the consent form, then introductions and collecting demographic data, and then a brief overview of the service which allowed the researcher to facilitate a more natural conversation about the service and its context. The researcher's primary role within the focus groups was to clarify points, to keep the discussion on topic, and to prompt further discussion if conversation dried up.

Analysis

Focus group data were transcribed and then analysed using Thematic Analysis (Braun and Clarke, 2006). Each transcript was read, reread and then coded; an example of initial coding can be found in Appendix K. Codes were then sorted into themes and

the relevant data was collated within the identified themes. Participants had also been asked what they considered to be the most important thing that had been said during the focus group; their answers were used to inform the initial codes, and mapped against the final coded themes. Potential themes were then reviewed at the code level, considering whether collated extracts cohered together meaningfully, and at the thematic map level, considering whether the thematic map 'accurately' reflected the meanings evident in the data set as a whole. Themes were then refined, defined and named, and the data within each theme was organised into a coherent and internally consistent account with an accompanying narrative. An example of a theme and subtheme with quotes can be found in Appendix L.

Researcher's Position

The researcher was a white British female Trainee Clinical Psychologist in her early 20s, who had not experienced perinatal mental health problems or working in a perinatal mental health service and had never had a child. The psychological lens brought to the research may have influenced the research focus, the discussions in the focus groups and the analysis of the data, however she attempted to remain neutral during the research process and utilised reflective practice groups, supervision with two supervisors, and peer supervision with colleagues to ensure a variety of viewpoints had been considered.

Quality

Input was sought from one perinatal mental health team throughout the design of the research to guide the research questions and ensure the suitability of documents such as information sheets and consent forms. Various measures were taken during analysis to ensure the research was conducted with sufficient rigour and transparency, as per

Elliott, Fischer and Rennie's guidelines (1999). These included discussing the coding

process with peers during reflective practice groups, utilising research supervision, and

keeping a reflective diary to facilitate consideration of the researcher's possible biases

during the process (Appendix J). Finally, direct quotations are used to exemplify the

results, to ensure the research remained inductive and to minimise the effect of the

researcher's individual assumptions and perspectives.

Results

Four main themes emerged from analysis. There was consistency in the themes

across the three participating teams, suggesting that these might be relevant to all

perinatal mental health services. The diagram below shows the main themes and how

they relate to each other. *Ways of practising* was felt to be influenced both by *Mother's*

context and S*ervice context*, however *Mother's context* and *Service context* did not fully

overlap. *Professional's qualities* was felt to be firmly embedded within the way the

team practised, and again inhabited the space in which mother's context and service

context overlapped.
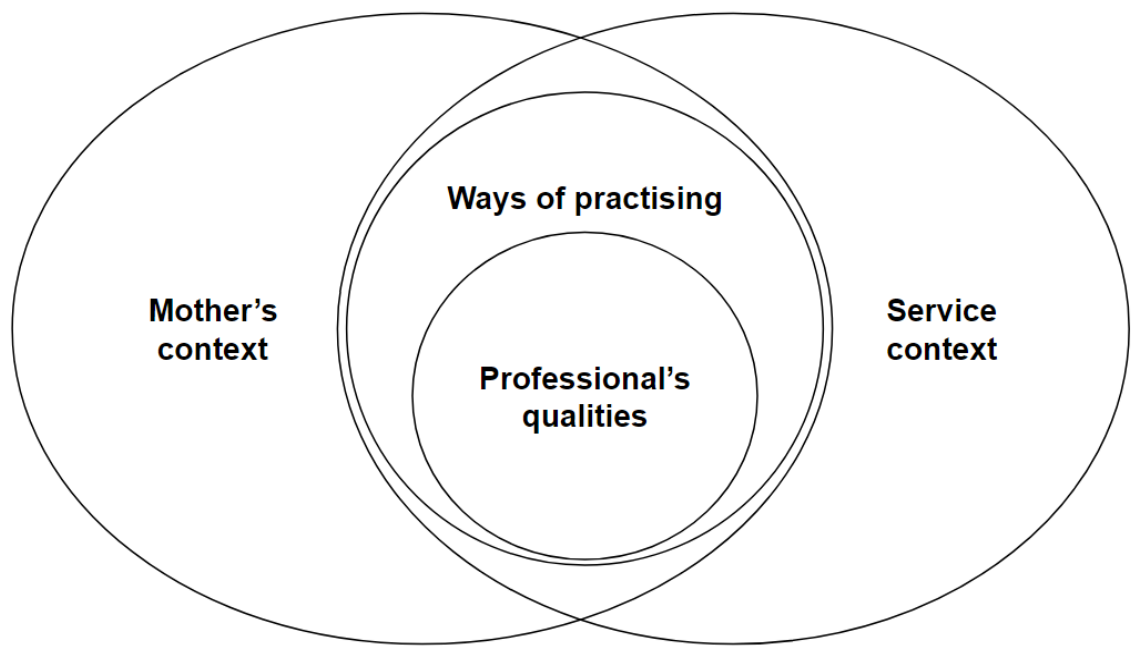
Figure 2. Diagrammatic representation of how the main themes relate to each other

Two additional themes were also identified during the analysis, which were felt to interact differently with the data. These were also consistent across the teams.
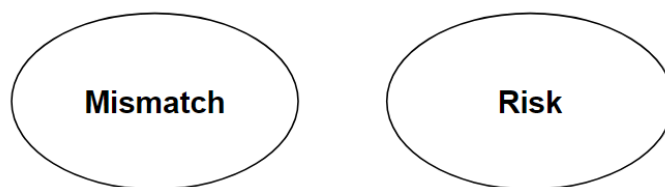
Figure 3. The two additional themes

The two additional themes were felt to relate to the main themes in the following way. *Mismatch* occurred in the space where *Mother's context* and *Service context* overlapped, but did not directly map onto one another. *Risk* impacted on all levels of the service, from the national service context to how each team practised, to each professional individually.
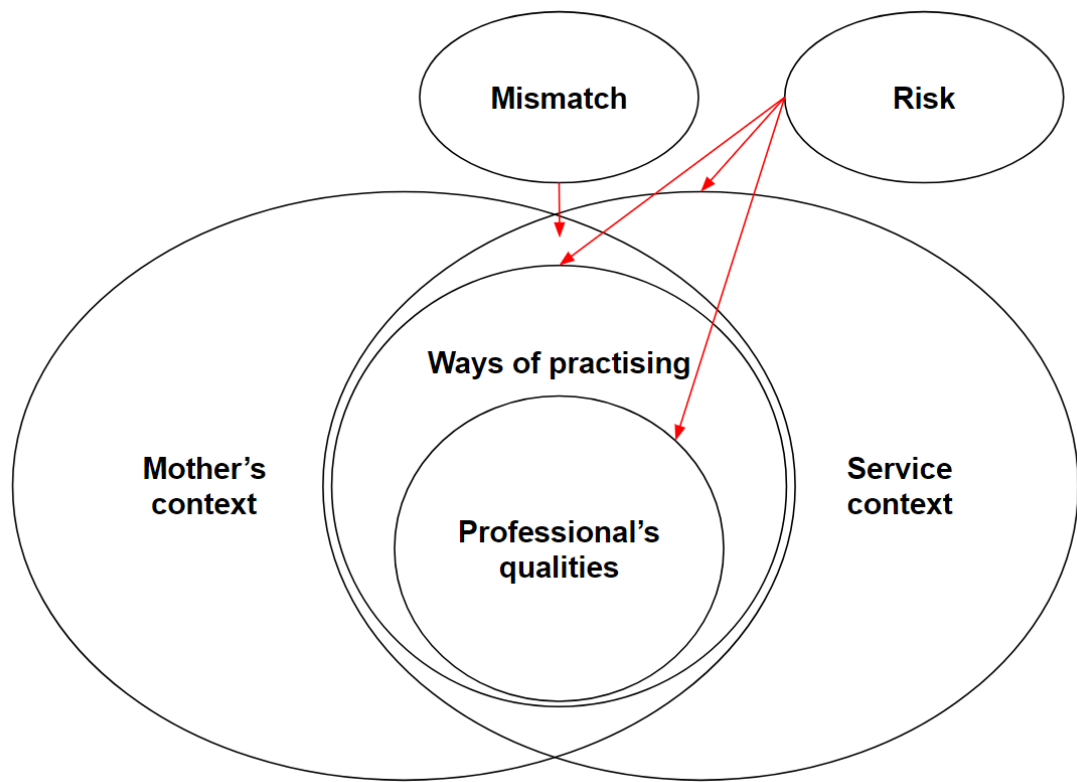
Figure 4. Diagrammatic representation of how all themes linked to each other

Kaiser (2009) highlighted that deductive disclosure can be a significant problem in qualitative research, especially when the pool from which participants are drawn is small. The quotes used to illustrate these themes are therefore not credited to any one participant or team in order to maintain anonymity, and pseudonyms were used when there was conversational exchange within a quote.

Mother's context

This theme referred to the various aspects of a mother's life that contribute to wellbeing and mental health problems, both in and outside the perinatal period. The contributing factors that staff discussed can be broken down into three subthemes: personal factors, interpersonal factors and societal factors.

Personal

There was a consensus by staff that the mental health problems mothers present with often link strongly to their historical experiences. They spoke about this in terms of past experiences and traumas creating a vulnerability that makes women susceptible to mental health difficulties once the baby arrives. Considering these risk factors can enable staff to identify and support women who might have additional vulnerabilities, meaning they receive support earlier and have better outcomes.

'a lot of secondary mental health care clients have had traumatic or abusive childhoods and but you might find that someone's always saying they've been a bit more keyed up, they've been a bit more on edge, and then we can talk about, the early postnatal period as being very anxiety provoking for anybody, that with your extra vulnerability that you're bringing to this'.

Participants felt that another key personal factor was the mothers' sense of self-worth. There was recognition of the importance of focusing on the mother not as a mother, but as a person, to increase their sense of value.

'this is not just about a baby in a womb, you are not just a vessel'.

'it's time for them, like somebody focuses on them and how they are and how they feel'.

Mothers were positioned within the context of their individual experiences and their family history, with participants describing a generational effect of parental mental illness, or their past experiences as a motivator for personal growth.

'the problems are generational, they were maybe brought up in a difficult family situation, experienced trauma when they were growing up and, you know you almost see it come through families'.

'they have a horror of perpetuating the difficulties that their parents had and the suffering that they'd suffered as children'.

Interpersonal

Participants talked a lot about the various relationships in mothers' lives around the perinatal period and the importance of these as protective factors or additional stressors.

Participants discussed a trend for women presenting at perinatal mental health services to have had pervasive difficulties with relationships throughout their lives:

'are we really the personality disorders service for women of childbearing age, cause that's how it feels isn't it'.

The attachment relationship between mother and baby was highlighted as particularly important, both in terms of the risk when it goes wrong:

'someone who's severely depressed who has a depressed affect on their face, that child is not simply gonna be distressed within seconds but is going to grow up with that stressor affecting their own cognitive and emotional development'.

and in terms of the positive impact that it can have:

'the, impact of the relationship on the mother and child is actually quite often intertwined in the mental health difficulties with quite a lot of the women as well, so if they're able to get better with the baby it helps with that.

This means specialist training around the attachment relationship is beneficial for staff, and specialist professionals such as parent-infant psychotherapists are a valuable addition to perinatal mental health teams.

Societal

Societal factors were considered a significant contributor to perinatal mental health difficulties. The way staff talked about this suggests perinatal mental health services need to ensure social issues relating to safety and survival are attended to first, before, for example, in-depth psychological therapy. This could be achieved through joint working with social services.

'it's sort of in terms of hierarchy of needs without money, somewhere safe to life, food, safety, you know, somebody's mental health is gonna be a mess isn't it'.

'there's so many other variables for example uh financial issues housing problems domestic violence drug and alcohol problems'.

One particular societal factor that staff discussed was the stigma of perinatal mental health difficulties, which they described as a barrier to accessing help and a compounding factor in mental health problems.

'she'd left it such a long time feeling unwell before she'd presented to any services, because of stigma'.

Staff therefore considered it part of their role to try and dispel that stigma, ensuring women knew that *'their needs are as important as baby's'*, and didn't feel guilty about asking for support. They also noted that stigma appears to be less of a problem now compared to how it used to be, perhaps reflecting the start of a paradigm shift in societal views:

'that was seen as like a taboo… …compared to now it's being normalised and actually accepting that this kind of stuff [perinatal mental illness] does happen and therefore let's talk about it'.

Service context

This theme related to the national and organisational context around the service. The subthemes discussed were: anxiety for future of service, and specialist service.

Anxiety for future of service

The way professionals described the service context gave a sense of urgency that others understand how vital it is for perinatal mental health services to remain specialist and sufficiently resourced. This may in part be due to the current context of perinatal mental health services in that they have received significant funding in a short space of time. Staff were concerned that this would not last, and funding for perinatal mental health was going to *'fall off the agenda'* and that specialist teams would become integrated into CMHTs *'and vanish'*.

Staff felt that if perinatal mental health services stopped receiving funding and were no longer specialist, it would not be possible to provide effective intervention for women in the perinatal period, and this would increase the risk for women suffering from perinatal mental health problems. They described there being nuances and risks to working in perinatal mental health that generic mental health services struggle to pick up on due to not experiencing them often enough.

'the concept of a prophylactic admission, doesn't really hit the radar of general community mental health teams, whereas with teams who are seeing women day in day out they might realise that just a few days before and a week or so after the delivery could make all the difference'.

'there isn't enough perinatal patients for them [CMHTs] to get that… …critical mass of patients, and tend to underestimate risk'.

Staff described the need for a high level of resources to be able to do their jobs effectively, due to the magnitude of the job:

'to trawl back into someone's childhood and all the childhood experiences and all sort of early adolescent experiences and all sort of life experiences, trying to make sense of that from a psychological point of view and supporting that going forward, all in a short space of time… that's why it's so expensive to run, you need highly specialised highly trained staff'.

'the importance of having lots of different skilled staff, because I think that having those different skills is helpful to mums who we come into contact with'.

Ways of practising

This theme was strongly informed by the theme of mother's context, which is congruent with the NICE guidelines around person-centred care informed by the needs of the individual (NICE, 2011). Subthemes identified were: person-centred care, and prevention.

Person-centred care

Professionals highlighted the importance of individualised care during the perinatal period as each women's needs may be entirely different and encompass a lifetime of experience. This care embodied the 'holistic' approach frequently talked about in NICE guidelines (2011), and staff felt it required a diverse and highly skilled multi-disciplinary team to put it into action.

'I think it's like a trivial pursuit cheese... where there's lots and lots and lots of factors come to play at the time of your life when you're having children, and that we see that and a good perinatal services see that and it's not just about one bit, and that mental health care, good mental health care like the biopsychosocial comment or discussion I suppose is about looking at someone's whole life'.

The way in which staff talked about their practice showed that mothers were at the forefront of their minds when making decisions about how best to care for them, ensuring they receive the care they feel they need, rather than staff making assumptions

on their behalf. This also helps boost a mother's sense of self-worth as it puts the focus on them.

'there's loads of questions I have to ask but I also want to hear your story, like tell me how things are for you today, how have they been, and start with listening, that's the priority'.

Staff also talked about how crucial it was for them to be able to practise flexibly, in order to meet the needs of women as and when they arise. This was reflected particularly in the need to be able to respond quickly, for example when referrals come in for a woman who is already 36 weeks pregnant.

'you can't have someone sitting on your case, on your waiting list for 6 to 8 weeks because then you'll have had, you know it's always like [laughter] it's a bit late isn't it'.

Flexible working was understood to increase engagement with therapeutic activities. Engagement issues were often linked to societal aspects of the mother's context. Mothers were reported to struggle more to engage with services when they were less physically accessible:

'where we are it's quite difficult to get to for some mums because here, you know, they've got no transport'.

They were also reported to struggle when there were less salient barriers to accessing them such as fear of judgment or inflexible service rules:

'Angie: when you walk into a normal mum and baby group it can feel quite excluding or quite competitive or there's a right way to parent your child... ... [in the therapeutic group, they can talk about] things that might really or they might feel really stigmatised talking about in other places; Stephen: it's non-judgemental isn't it I think'.

Prevention

Preventative care was cited as one of the most effective and beneficial ways of working. This was frequently discussed in conjunction with the generational effects of perinatal mental health problems.

'good care in this period is good in a way which can yield fruits in a multi-generation fashion'.

Prevention was also linked to service aspects as staff felt preventative working can lessen the impact on services in the future (linking to the subtheme of resources), but services need to be commissioned to work with women who are well and not just women who are already unwell. They emphasised that this might not be something that is easily backed up by outcome measures, but should be recognised.

'Mark: [reducing the number of women who] get admitted, and home treatment, and that is all the time that that is reducing suffering it's also reducing the you know resources the use of resources...; Cheryl: yeah, and impact on the whole family you know it's massive'.

'keeping people well is really important and needs investment and thought given to it, and sometimes that won't show in your data as well'.

It also came up in relation to the importance of perinatal mental health services remaining specialist services as in staff noted a trend towards relapse if specialist care was unavailable in a mother's locality.

'she'd been very unwell and she'd assaulted a partner and it ended up that she'd, on a forensic ward, and it ended up that she'd lost care of her first child, but then I think when she had her second child she came into the care of perinatal services and actually she's been able to keep I think it's two'.

Professional's qualities

Subthemes that came up in this theme were: experience, and relating to mothers.

This theme was closely linked to *Ways of Practising*, however *Ways of Practising* focused on the attitude of the team as a whole, whereas *Professional's Qualities* relates more to the individual.

Experience

Staff often mentioned '*learning on the job'* and described having had little to no perinatal mental health specific teaching during their training, which means reflective practice groups and supervision may be invaluable to facilitate on-the-job learning. They described how this is changing, but often only in areas that have perinatal mental health services as professionals in the services are the ones who provide teaching and placement opportunities. This presents a barrier to setting up specialist services in new localities.

'I've taught at University, there are some modules where they do now want specific lectures on perinatal mental health, but I remember when I was at university… …there wasn't anything in maternity about mum's mental health'.

'it's a lottery system though. I think Patrick and Gloria they teach at University so if there's a perinatal mental health service or an MBU within your locality you'd access that, so all the students who study within our local Universities, well [locality] in particular, can access it here. But if there isn't an MBU or perinatal service close to where you're studying, you won't have access to that'.

Experience was discussed in relation to the importance of perinatal mental health services existing as a specialist service, in order to ensure there are sufficiently qualified staff to recognise cases that are appropriate for perinatal intervention – particularly cases where there is a high level of risk to the mother or baby.

'we can pick up those cases which is for other people oh it's just a routine case… we can see the risks, we can see the potential problems, and we can do things differently or advise people to do things differently'.

Relating to mothers

Staff felt their interpersonal skills were particularly relevant and important in relation to engagement with women, and in relation to women's previous experiences of relationships. They described how *'you might have seen them more than any other professional in that time of their life'* and how important the relationship they have with women can be for women's coping and recovery during the perinatal period, especially

in relation to women who have had negative historic experiences with seeking support from others, or have struggled with relationships.

'but actually that's critical and crucial for some of those women, that they have that one point of call, that one person who they can build up trust with'.

Compassion was considered to be a driving factor behind staff's attitudes towards women in their service, and staff recounted going above and beyond to help women, or being creative in their approach to ensure women were able to access the most appropriate care. This suggests that if compassion is lost, the quality of care that women receive would reduce. Therefore services should consider workload, reflective spaces and supervision time to combat compassion fatigue.

'*I think what's really nice in this team is that we've all got the same attitude, vision, um, ideas about human beings, and compassion, and I think that comes through in the work that we do'.*

'everybody here really cares about the people that come into our service and really care about the outcomes for them, and do go the extra mile'.

Risk

The theme of risk was an undercurrent throughout all three focus groups. It appeared to be a driving force behind ways in which staff practised on both an individual level (i.e. being able to practise flexibly so risk events can be responded to quickly) and a service level, with services working together to contain risk: *'it feels better to know that you're not on your own caring for somebody that you think might be*

having suicidal thoughts'. It was also discussed in the context of services needing to be specialist, as staff felt that generic mental health services may not identify risks effectively in perinatal cases, or women may not reach the threshold to receive a service at all. The risk was perceived to be what justified the higher level of staffing and resources.

'you might have home treatment teams who believes that somebody doesn't meet their threshold where actually because they have a baby, because they're pregnant, the threshold should be different'.

The discussions around risk often came back to the risks of untreated mental illness in the perinatal period, which staff discussed in terms of the long term impact on the baby, and the increased recovery time for the mother associated with a longer period of untreated mental illness. This risk factor may be where the feeling of being a *'vessel'* for one's baby comes in for mothers.

'duration of untreated illness can make the longer that people feel poorly the harder that can be to tackle, and the more damage can be done to their life their quality of life their relationships, their relationships with older children perhaps, with partner, with, people can be off work'.

'I think for the risk benefit people can just think about very understandably the risk to baby, but you're trying to give them the breadth of that, the evidence or the knowledge around the risk of untreated illness of deterioration of illness, the risk to baby of you not being a responsive mum, of you being a sad mum, there's many more risks in perinatal mental health problems than just the biological ones'.

Mismatch

Finally, a key theme running throughout the groups was where the mother's context and the service context did not match up. This provided a dilemma for staff as when face to face with women who were suffering, they wanted to be able to care for them as best they could; the service context did not always make this straightforward. One staff member described a standardised care model as '*like going into a shoe shop, and you're a size 6, so you can have these 3 styles of shoes, and that's all you can have, that's all we do in a size 6, and that to me is a nonsense'.*

Staff talked about feeling as though there was no space for compassion in their work as it had been squeezed out by funding cuts: '*it got lost somewhere down the NHS policies... briefly revised with the 6 Cs, and now we can't afford those any more'.* One staff member said '*it goes against everything I learnt about nursing when I was training'.* This, too, may contribute to compassion fatigue and a reduced quality of service being provided.

Others described how they feel they have to '*fudge it'* to ensure women receive adequate care:

'*if we can use our discretion to ensure they get a service then that feels fairer and more ethical'.*

'*interpreting somebody's level of difficulty... ...so that you can offer a service'.*

In some cases commissioners are aware of the mismatch between what they are asking on paper and what they want services to provide:

'I would also say that actually the commissioners are fully aware that we smudge it, because I have told, I've been really honest with them and said that no actually this model isn't really what perinatal services should be about, it should be about that fluidity, that flexibility, um, so they say that 'what do you do' and I say 'well actually sometimes we'll maybe be more creative when we're doing our cluster scores', and they've said 'well... we're really pleased that that's what you're doing', so again that I think from a commissioning level, they're very passionate, they're really supportive actually'.

This theme is important because it highlights areas for growth and for service development; it highlights issues which need responding to. It may represent the areas where women's reported dissatisfaction with services stems from.

Discussion

This research aimed to explore themes in staff discussion of perinatal mental health, including perinatal mental wellbeing, perinatal mental health problems, and perinatal mental health care. It also aimed to explore how staff understand perinatal mental health problems, and how this understanding may influence practice. This is apparent in the way the themes link together. Four main themes were evident in staff discussion: mother's context, service context, ways of practising, and professional's qualities. These were inextricably linked, with care practices being shaped by mothers' needs and the context of the service, and professional's qualities enabling effective care. Two underlying themes were also noted: mismatch between what staff felt they wanted to do and what they were able to do, and risk being a driving factor in service development and practice. These findings will be discussed within the context of the

wider literature and societal discourses, and implications for clinical practice and future research will be considered.

An overall trend in the data was to discuss perinatal mental health problems in a holistic fashion, considering psychological and social aspects to their origins and to the subsequent interventions. This is in line with the biopsychosocial model (Engel, 1980) which is widely used today in mental health services. Staff understood perinatal mental health problems to be significantly contributed to by historical experiences in a woman's life, combined with the stress of living up to society's expectations of motherhood and the day-to-day stresses of caring for an infant. This appeared to guide their practice to revolve around the psychosocial elements; though this may be affected by the greater number of specialist mental health nurses compared to psychiatrists. Nonetheless, this practice is in accordance with NICE guidance (2014) but in contrast to mothers' reports of their experiences of perinatal mental healthcare, where they felt the focus was too much on biological and obstetric aspects (Megnin-Viggars et al, 2015).

This discord may be explained either by a negative bias in the research whereby studies aim to identify problems to fix (Sheldon & King, 2001), or by the fact that specialist perinatal mental health services are not available in every locality. The work of the Maternal Mental Health Alliance to highlight gaps in national service provision has resulted in perinatal mental health services receiving funding within recent waves, and has informed updates to NICE guidance. This has resulted in changes to existing services and development of new services where none previously existed. Research completed only a few years ago may therefore already be outdated and not an accurate reflection of current practice. Additionally, there remains inconsistency in levels of service provision across the country (Jomeen & Martin, 2014; Royal College of Obstetricians and Gynaecologists, 2017), and professionals in wider health or mental health services may not be sufficiently skilled to manage perinatal mental health

problems to as high a level as specialist services, as suggested by this study. Women who reported being unsatisfied with their care may have received care from newer specialist services, or from non-specialist services.

Staff emphasised the importance of not just being skilled enough to recognise and work with the nuances of perinatal mental health problems (such as working with the mother-infant relationship), but the fact that to work effectively with perinatal mental health problems, sufficient skills and resources are required to deal with a lifetime of experiences in a short space of time. Again, this is in line with the biopsychosocial model (Engel, 1980), attending to the psychological and social dimensions of illness in addition to the biological. Integrative formulation (Weerasekera, 1996) may also be beneficial in perinatal mental health services as it allows interpretation of mental health problems to be individual, selecting aspects of frameworks to guide understanding from whichever theory feels most salient to the individual at that time. This would enable mothers to feel listened to and understood, and is especially helpful considering the 'umbrella term' nature of the diagnosis of personality disorder, whereby various different presentations may all come under the same diagnosis but require different approaches to treatment. Clinical Psychology may be able to support perinatal mental health services in this by facilitating formulation meetings.

In attempting to respond to mothers compassionately and work with their presenting problems effectively, staff appeared to run into difficulties reconciling their hopes for treatment with service constraints. This is represented within the data as the theme of 'mismatch' and pervaded the entire dataset. Staff felt that compassion was no longer affordable for the NHS, and felt frustrated by the short term approach when long-term benefits can be gained by intervening more effectively earlier. This is in line with research into barriers to compassionate care in midwifery (Deery & Kirkham, 2007) and

health care (Thompson & Ciechanowski, 2003). Staff used the example of the need for CAMHS interventions for the infant if the mother's perinatal mental health problem has not been effectively managed. This frustration is unlikely to be unique to perinatal mental health services and may be indicative of a wider systemic problem within the NHS. Long term investment in perinatal mental health services was highlighted as important by staff, but staff had concerns that current funding levels would not be sustained as perinatal mental health is currently the '*shiny sexy thing*'. Potential shifts in government agendas regarding the focus on mental health services in the future led to staff wondering whether funding for perinatal mental health may '*fall off the agenda*'. This could pose challenges to providing effective preventative care that has long term benefits, but may not demonstrate short term results in outcome measures used to assess service performance. It is possible that this uncertainty may also contribute to the positioning of perinatal mental health services '*on the outskirts*', as staff want to be better linked to other services but fear becoming integrated and losing their ability to provide specialist care.

The findings of this study may also be applicable to other areas in terms of the difficulties with engagement. Staff said themselves that the client group they struggle most to engage – those with longstanding psychological difficulties such as personality disorders – was the same in other services they had previously worked in. Therefore it follows that other services would also benefit from the flexibility that staff cite as being crucial in engaging these women. Staff might benefit from being supported to consider alternative formulations such as trauma-informed care to guide their understanding of what role services may play for these women (Hodas, 2006). Additionally, staff described the difficulty in engaging these and other women when their basic needs (as per Maslow's Hierarchy of Needs; 1943) have not been met. This lead them to emphasise the importance of multi-agency working to ensure needs such as finance and

housing are met – and, for some women who may be socially isolated, the importance of just having a positive relationship with someone who responds to them with compassion. This is backed up by the wider literature (Watkins, 2001). These social issues may represent a particular difficulty due to their potentially cyclical nature, whereby once someone has been labelled with a mental health problem and has been struggling, they become stuck in a cycle of social disadvantage. This phenomenon has been observed in wider mental health (Tew et al, 2011). Social problems (finances, housing, drug and alcohol problems) impact negatively on mental health, which in turn impacts on the ability to manage social problems.

Another social factor highlighted by this study as a contributor to difficulties in the perinatal period was the stigma associated with perinatal mental health problems. This has been established by other literature as a barrier to seeking help (Hadfield & Wittkowski, 2017; Staneva, Bogossian & Wittkowski, 2015). Participants in this study powerfully described the idea still held by individuals in current society that if you have a mental health problem, you are not fit to be a mother. This echoes historic perspectives on mental health whereby individuals with mental health problems were not believed to be worthy of having jobs or contributing to society (Sayce, 1998), and women with mental health problems were strongly encouraged to avoid becoming pregnant or to terminate pregnancies (Sayce, 1997). A paradigm shift occurred in perspectives on mental health, moving from institutionalisation to normalising mental health with community care (World Health Organisation, 2001). Staff in this study expressed the need for perinatal mental health to be similarly widely understood and normalised, in order for mothers to feel less stigmatised, better able to seek help, and to avoid getting caught in a cycle of guilt that compounds any mental health problems they are experiencing.

A similar vicious cycle may contribute to mothers' difficulties with self-esteem. Staff noted that confidence in their ability to parent their child and in their social representation as a mother, such as appearing competent at mother and baby groups, was important to mothers and contributed to their experience of mental health problems. This is consistent with literature suggesting that perinatal mental health problems impact on a mother's perceptions of her parenting abilities (Newman, Stevenson, Bergman & Boyce, 2007; Ramsauer & Schulte-Markwort, 2015), and this is likely to be a reinforcing cycle consistent with Cognitive Behavioural theory (Harvey, 2004) whereby the mother avoids situations in which her ability to parent her child will be judged, and therefore never proves to herself that she is competent. It may also result in missing out on opportunities to improve her parenting skills if, for example, the fear of social judgement prevents her from attending mother and baby classes. Women generally report feeling pressured to be a 'perfect mother' after giving birth (Staneva, Bogossian & Wittkowski, 2015). If a mother has additional difficulties around self-esteem due to mental health problems, being socially disadvantaged or being a member of a stigmatised group, these pressures may be magnified, as they are in other populations (Cooke, 2014). Staff at one service stated that informal groups with a non-judgmental atmosphere were crucial for breaking this cycle as mothers did not feel too intimidated to attend, they were able to share their difficulties honestly without fear of judgement, they were able to learn by observation from other mothers, and it provided staff with an opportunity to gently guide mothers toward better parenting behaviours.

This difficulty with self-esteem may also be impacted upon by societal discourses positioning the mother as a 'vessel' for the baby, as staff in one team put it and as it has been described in wider literature (Gross & Pattison, 2007). This discourse detracts from the mothers' inherent value as a person and instead links their self-worth not only to their ability to care for their baby as described above, but also to their ability

to provide an optimal physical space in which the baby can grow. Mothers have described an obstetric focus to their care throughout the perinatal period (Megnin-Viggars et al, 2015), and may therefore internalise an unintentional, implicit message from healthcare professionals that their wellbeing is less important than their baby's. Staff acknowledged the importance of keeping the baby healthy and safe – this often came up in the theme of 'risk' - but also emphasised that mothers must be made to feel they are valued for themselves, and given time to focus on them without necessarily linking it to motherhood and the baby.

The findings of this study should be considered within its strengths and limitations. This research was clinically driven and used an inductive methodology to minimise confirmation bias (Gioia, Corley & Hamilton, 2012), and the findings were consistent across the three groups, suggesting reliability. The primary limitation was the small sample size, which means results cannot be assumed to be representative of the views of other perinatal mental health professionals. On the other hand, qualitative research is intended to be an in depth exploration rather than to be transferable (Willig, 2008), which this research has achieved. However, the small sample size combined with the small size of the profession also meant that the researcher was unable to use demographic factors to enrich the analysis as it would have compromised participants' anonymity. Additional detail and interpretation could also have been achieved by using a more in depth analysis (such as Critical Discourse Analysis; Fairclough, 2013), however this study was intended to explore the data and give a broad overview, as the understanding of staff has not been explored in previous literature.

The use of qualitative methodology means results may have been influenced by the researcher's preconceptions and individual interpretations. For example, as a result of her training in Clinical Psychology, it is likely that the researcher had a bias towards psychosocial understandings of perinatal mental health problems. It is also likely that

the researcher had a positive bias towards the work done by staff teams due to also being a worker in health and social care. However, these biases were brought into conscious awareness through regular supervision and reflective practice, rather than being allowed to unconsciously influence the data and decisions made within the research (Dietrich, 2010).

The use of focus groups could also be interpreted as a limitation as focus group participants may over-intellectualise and minimise emotions (Krueger & Casey, 2015). Individual interviews were a viable alternative, however the researcher considered focus groups to be more representative of clinical practice as perinatal mental healthcare services use a multidisciplinary team approach. Finally, this study was limited to the UK, however similar issues have been mentioned in the United States and Australia, therefore the findings may be of relevance beyond the UK.

Conclusions and implications

This study provides insight into the way perinatal mental health staff understand and wish to treat perinatal mental health problems, and raises considerations for the development of perinatal mental health services. Staff highlighted the importance of holistic care that acknowledges women as more than just 'vessel for their baby', and specialist services that have the resources to provide this care. Care also needed to be person-centred and able to work with social issues such as financial disadvantage or stigma associated with mental health problems. There appeared to be a tension between the care staff wanted to provide and the care they were able to provide as a result of service constraints.

Whilst keeping limitations in mind, implications can be drawn for the continued development of perinatal mental health services, as well as other professionals working with women during the peripartum. Firstly, staff need to be given the opportunity to

acknowledge women as whole individuals with a lifetime behind them, and it should be held in mind when services are busy that staff may struggle with the mismatch between what they want to do for women and what the service environment permits them to do. This must be managed in order to prevent compassion fatigue (Figley, 2002), especially as staff note a tendency to go 'above and beyond'. Reflective practice, resilience training and clinical supervision using therapeutic models (i.e. trauma informed care, attachment theory) could be provided to achieve this with additional funding for Clinical Psychology posts. Secondly, services need to be able to practise flexibly and to use assertive outreach techniques in engaging women, and rigid discharge rules should be carefully considered as they may be perpetuating a cycle of disadvantage. Thirdly, a non-judgemental approach should be embodied by any staff member working with women during the peripartum and perinatal mental illness should be normalised in order to prevent stigma from continuing to prevent women from seeking support. Fourthly, services should be set up in a way that allows for preventative intervention, including preconception, and for interventions to begin as swiftly as possible; this is in line with current recommendations. Finally, these implications together reinforce the message staff gave throughout the focus groups: that perinatal mental health services need to remain specialist and not become integrated into CMHTs, lest they lose the ability to practise in line with the above recommendations.

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Part Three: Appendices

Appendix A

Guidelines for Authors for Submission to *Infant Mental Health*

Author Guidelines

NIH Public Access Mandate

For those interested in the Wiley-Blackwell policy on the NIH Public Access

Mandate, please visit our policy statement

Author Services – Online production tracking is now available for your article

through Wiley-Blackwell's Author Services.

Author Services enables authors to track their article - once it has been accepted -

through the production process to publication online and in print. Authors can check the

status of their articles online and choose to receive automated emails at key stages of

production. The author will receive an email with a unique link that enables them to

register and have their article automatically added to the system. Please ensure that a

complete email address is provided when submitting the manuscript.

Visit http://authorservices.wiley.com for more details on online production tracking and

for a wealth of resources including FAQs and tips on article preparation, submission

and more.

- Copyright Transfer Agreement
- Permission Request Form

Author Guidelines

The *Infant Mental Health Journal* (IMHJ) is the official publication of the World

Association for Infant Mental Health (WAIMH) and is copyrighted by the Michigan

Association for Infant Mental Health.

Information for Contributors

Reflecting the interdisciplinary nature of the field, its international focus, and its commitment to clinical science, the IMHJ publishes research articles, literature reviews, program descriptions/evaluations, clinical studies, and book reviews on infant social–emotional development, caregiver–infant interactions, and contextual and cultural influences on infant and family development. The Journal is organized into three sections: Research, Clinical Perspectives, and Book Reviews. Research focuses on empirical research. Clinical Perspectives allows for more diversity in types of submissions and is designed to advance infant mental health practice and scholarship. Requests for book reviews should be sent by the author or publisher to the Editor In Chief. Please do not send a copy of the book until the request is approved.

The Journal welcomes a broad perspective and scope of inquiry in infant mental health and has an interdisciplinary and international group of associate editors, consulting editors, and reviewers who participate in the peer review process. In addition to regular submissions to the Journal, proposals for special issues or sections are also welcome. These should be discussed with the Editor In Chief prior to submission.

MANUSCRIPTS for submission to the *Infant Mental Health Journal* should be forwarded to the Editor as follows:

1. Go to your Internet browser (e.g., Netscape, Internet Explorer).
2. Go to the URL http://mc.manuscriptcentral.com/imhj
3. Register (if you have not done so already).
4. Go to the Author Center and follow the instructions to submit your paper.
5. Please upload the following as separate documents: the title page (with identifying information) and all remaining files without any identifying information, including the body of your manuscript, and each table and figure.

Please note that the cover letter is uploaded directly into a field in the on-line submission platform.

6. The Title Page should include a discussion of any conflicts of interest, human subjects approvals, and funding. Acknowledgements may also appear here. The Infant Mental Health Journal complies with all relevant recommendations from the International Committee of Medical Journal Editors in these areas.

7. Your abstract should be uploaded into the appropriate field at the submission website and should also be included in the main text of the manuscript. The abstract in the manuscript must include 3-5 key words listed at the end of the text.

8. Please note that this journal's workflow is double-blinded. Authors must prepare and submit files for the body of the manuscript and any accompanying files that are anonymous for review (containing no name or institutional information that may reveal author identity).

9. All related files will be concatenated automatically into a single .PDF file by the system during upload. This is the file that will be used for review. Please scan your files for viruses before you send them, and keep a copy of what you send in a safe place in case any of the files need to be replaced.

10. Style must conform to that described by the American Psychological Association *Publication Manual* , Sixth Edition, 2009 (American Psychological Association, 750 First Street, N.E., Washington, D.C. 20002-4242). Authors are responsible for final preparation of manuscripts to conform to the APA style.

Manuscripts generally do not exceed 10,000 words and will be assigned for peer review by the Editor or Associate Editor(s) and reviewed by members of the Editorial Board and invited reviewers with special knowledge of the topic addressed in the manuscript. The Editor retains the right to reject articles that do not meet conventional clinical or

scientific ethical standards. Normally, the review process is completed in 3 months. Nearly all manuscripts accepted for publication require some degree of revision. There is no charge for publication of papers in the *Infant Mental Health Journal*. The publisher may levy additional charges for changes in proofs other than correction of printer's errors. Authors have the option to participate in Wiley's OnlineOpen program which allows authors of primary research articles to make their article available to non-subscribers on publication and archive the final version of their article. With OnlineOpen, the author, the author's funding agency, or the author's institution pays a fee to ensure that the article is made available to non-subscribers upon publication via Wiley Online Library, as well as deposited in the funding agency's preferred archive. For more information, please visit the OnlineOpen page.

Proofs will be sent to the corresponding author and must be read carefully because final responsibility for accuracy rests with the author(s). Author(s) must return corrected proofs to the publisher in a timely manner. If the publisher does not receive corrected proofs from the author(s), publication will still proceed as scheduled.

Additional questions with regard to style and submission of manuscripts should be directed to the Editor: Paul Spicer, PhD, at paul.spicer@ou.edu

Appendix B

Data Extraction Form

Data heading	Data
Title	
Author(s)	
Year	
Journal	
Geographical area	
Aim / focus	
Participants	
Sample size	
Design	
Main findings	
Conclusions	
Outcome measures	
Statistical analysis	
Quality assessment	
Limitations	

Appendix C

Quality Assessment Checklist

	Area	Topic	Item criteria	Original checklist
1	Abstract		Is the abstract clear and informative?	Sutherland
2	Introduction	Background	Is there an adequate literature review?	NICE
3			Is a clear rationale for the research presented?	STROBE
4		Objectives	Are the aims and objectives of the study clear?	CASP, Downs and Black
5	Method	Participants	Is there a theoretically justified rationale for which participant population is recruited from?	CASP
6			Are participant demographics reported?	STROBE
7			Is there a comparison group?	Sutherland
8		Recruitment	Is the recruitment strategy appropriate to the aims of research?	CASP
9		Sampling	Is the sample big enough?	STROBE
10			Is the sample representative of the target population from which it was recruited?	MMAT
11		Study design	Is the study design appropriate to the aims of the study?	NICE
2			Is the study design clearly described?	STROBE
13		Data collection	Are the methods of data collection clearly described?	NICE
14			Are the methods of data collection rigorous and systematic?	NICE
15			Was appropriate data collected, relating to the aims of the research?	NICE
16		Measures	Are the measures: valid; reliable; relevant?	MMAT
17		Outcomes	Are the outcomes to be recorded clearly described?	Downs and Black
18		Statistical methods	Are the statistical methods used appropriate: to the study sample; to the research design?	Downs and Black
19		Bias	Is bias adequately considered and accounted for or attenuated where	CASP, MMAT

			possible?	
20		Analysis	Is the analysis appropriate to the aims of the study?	MMAT, Downs and Black
21			Is the analysis clearly described?	STROBE
22			Is the analysis rigorous and reliable?	NICE
23	Results	Findings	Are the findings adequately described? Quantitative: reported in enough detail; numbers add up? Qualitative: extracts from original data included?	NICE, STROBE
24			Are the findings relevant to the aims of the study?	NICE
25		Participants	Response rates, drop-out rates and reason for drop out recorded?	STROBE, MMAT
26	Discussion	Key findings	Discussed in relation to hypotheses / research question?	CASP?
27		Interpretation	Are clear links made between the findings and other literature or clinical practice implications?	NICE
28			Are findings considered in the context of extraneous variables?	STROBE
29		Limitations	Are the limitations of the study discussed? In relation to the findings?	NICE, STROBE
30		Ethics	Are ethical issues considered: in relation to procedure; in relation to consequences of study's findings?	CASP, NICE
31		Generalisability	Is the generalisability of the study discussed?	CASP, STROBE

Appendix D

Quality Assessment Scores

Item	Blankley, Galbally, Snellen, Power & Lewis, 2015	Newman, Stevenson, Bergman & Boyce, 2007	Smith-Nielson et al, 2015	Conroy et al, 2012	Uguz, Akman, Sahingoz, Kaya & Kucur, 2008	Ramsauer & Schulte-Markwort, 2015	Lucarina et al, 2017	Hudson et al, 2017	Cordes et al, 2017	Conroy, Marks, Schacht, Davies & Moran, 2009	Apter, Devouche, Gratier, Valente & Nestour, 2012
1	1	1	1	1	1	1	1	1	1	1	1
2	0	1	1	1	1	1	1	1	1	0	1
3	1	1	1	1	1	1	1	1	1	1	1
4	1	0	1	1	1	1	1	1	1	1	1
5	1	1	1	1	1	1	1	1	1	1	1
6	1	1	1	1	1	1	1	1	1	1	1
7	1	1	1	1	0	1	1	N/A	1	1	0
8	1	1	1	1	1	1	1	1	1	1	1
9	1	0	1	1	0	1	1	1	1	1	1
10	1	1	0	1	0	0	0	1	1	1	1
11	1	1	1	1	1	1	1	1	1	1	1
2	1	1	1	1	1	0	1	1	1	1	1
13	1	1	1	1	1	0	0	1	1	1	1
14	1	1	1	1	1	1	1	0	1	1	0
15	1	1	1	1	1	1	1	1	1	1	1
16	1	1	1	0	1	1	1	1	1	1	1
17	1	1	1	1	1	0	0	1	1	1	1
18	N/A	1	1	1	1	1	1	1	1	1	1
19	0	1	0	1	0	0	0	1	1	0	0
20	1	1	1	1	1	1	1	1	1	1	1

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21	0	1	1	1	1	1	1	0	1	1	1
22	N/A	1	1	1	1	1	1	1	1	1	1
23	1	1	1	1	1	1	1	1	1	1	1
24	1	1	1	1	1	1	1	1	1	1	1
25	N/A	1	1	1	1	N/A	1	1	0	1	1
26	1	1	1	1	1	1	0	1	1	1	1
27	1	1	1	1	1	1	1	1	1	1	1
28	1	1	1	1	1	0	0	1	1	1	0
29	1	1	1	1	1	1	1	1	1	1	1
30	0	0	0	1	0	0	1	0	1	1	1
31	1	0	1	1	0	1	1	0	1	1	1
Total score / total score possible	25/28	27/31	28/31	30/31	25/31	23/30	24/30	26/30	30/31	29/31	27/31
Percentage score	89	87	90	97	81	77	80	87	97	94	87

Scoring: Yes = 1, No = 0, N/A

Appendix E

Epistemological Statement

'Epistemology' refers to *how* we know what we know (Crotty, 1998). The process of obtaining knowledge in research is based on assumptions held about 'what reality is' (Lincoln & Guba, 1985). The purpose of this epistemological statement is to outline the process by which the researcher reached the epistemological standpoint taken in this thesis. It will consider thematic analysis, social constructionism, and the role of the researcher.

There exists a continuum of epistemological positions that can be adopted when conducting research, which will impact upon methodological processes or 'research action' (Carter & Little, 2007). These range from positivist epistemologies, through post-positivist, to subjectivist. Positivist (also known as 'realist') epistemologies state that there are truths that can be known about the world, and positions scientific method as a mechanism to uncover these truths (Sousa, 2010). Positivist epistemologies link to deductive analyses which aim to test out a hypothesis. Post-positivist (or 'critical realist') stances suggest that while there are indeed truths to the world, these cannot be known with certainty due to the researcher's influence on what is being observed. Finally, subjectivist (or 'social constructionist') stances declare that there cannot be one absolute 'truth' that can be uncovered by science, because an individual's reality is constructed based on their own experiences and is therefore exclusive to that individual (Berger & Luckmann, 1991).

When initially researching this subject area the researcher noticed that there appeared to be a lack of data from staff in perinatal mental health services, compared to staff in other services, or the service users. There was therefore little data from which to construct a hypothesis to test out, so a positivist epistemology was rejected. The researcher wished to access the knowledge of staff, but did not wish to assume this knowledge to be a 'hard truth' (Burr, 2015), and wished to acknowledge the wider societal discourses that are drawn on when discussing perinatal mental health problems. Therefore this research sits between a post-positivist stance and a subjectivist stance.

A quantitative design was rejected as quantitative research fits more with positivist epistemologies, testing out hypotheses. The researcher was interested in gaining a more in-depth understanding of current understandings of perinatal mental health problems and perinatal mental health services, therefore the researcher elected to

use qualitative methodology. Interpretative Phenomenological Analysis (IPA; Smith, Flowers & Larkin, 2009), an 'examination of how people make sense of their major life experiences' was considered and rejected due to the researcher not wishing to focus on any one particular experience in staff's practice, but practice as a whole. Discourse analysis (Willig, 2008) was considered due to its ability to use language to unpick the constructs within the data, however the researcher wished to gain a broad overview of the themes staff discuss in relation to perinatal mental health problems and care as opposed to going into depth, and to consider the discourses that may affect this as a supplementary aspect of analysis rather than as the primary analysis. Thematic analysis (Braun & Clarke, 2006) was therefore considered to be the most appropriate method of analysis.

Thematic analysis can be positioned in either post-positivist or subjectivist epistemologies. It uses an inductive approach (Denzin & Lincoln, 2005), also known as 'bottom-up' research, generating codes from the data itself as opposed to creating codes from ideas in previous literature. A deductive analysis would not have been appropriate considering this research takes a new angle on the topic of perinatal mental health, and deductive analyses do not fit within subjectivist epistemologies. However it would be unrealistic to suggest that the researcher was not influenced by the literature surrounding perinatal mental wellbeing. The researcher themselves will also influence the research: Willig (2008) describes this as 'authoring' rather than 'discovering' knowledge. Some qualitative researchers believe this should be accepted as a constant in qualitative research, calling the phenomenon the 'double hermeneutic' (Giddens, 1987).

To conclude, the researcher positioned this study between post-positivist and subjectivist epistemologies, as it aims to access the views of staff but acknowledges these views may be influenced by contextual factors. The researcher elected to use a Thematic Analysis to generate themes around perinatal mental wellbeing, using an inductive approach to minimise biases resulting from the perspectives of both the researcher and surrounding literature.

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Appendix F

Ethical Approval Documentation

[removed for confidentiality]

Appendix G

Participant Information Sheet

Title of the study: Exploring how staff construct their understanding of perinatal mental health problems

We would like to invite you to take part in a research study which is looking at perinatal mental health staff's understandings of perinatal mental health problems. Before you decide if you want to participate we would like you to understand why this research is being done, and what it will involve for you. You can talk to others if you would like before you decide if you want to take part. The researcher will answer any questions you may have.

What is the purpose of the study?

This study is exploring perinatal mental health staff's understanding of perinatal mental health problems, in order to understand how services currently support mothers and how they would like to develop and support mothers in the future. To do this, a thematic analysis will be conducted on a transcription of focus group discussions between perinatal mental health staff. This will identify the sorts of themes that are discussed when talking about perinatal mental health and illness.

Why have I been invited?

You have been invited because you are a professional working in the field of perinatal mental health problems.

Do I have to take part, and what if I change my mind?

You are under no obligation to participate in this study. Participation is completely voluntary. If you decide to take part you will be asked to sign a consent form to indicate that you agree to take part. Even if you give consent to participate, you can still ask to withdraw at any time up to the point when the focus group takes place without giving a reason for doing so. Deciding not to participate, or withdrawing your consent later, will have no impact on your role at the service or relationships with your employer.

Due to the nature of the data collected from focus groups, it will not be possible to withdraw your individual data from the study once the focus group has taken place. This will be reiterated at the beginning of the focus group.

What will happen if I decide to take part?

If you decide to take part, you will be invited to a focus group with the researcher and any other members of your team who have shown interest in taking part. This focus group would be at a time and place that is convenient to the team.

During the focus group the researcher will ask you questions about your understanding of perinatal mental health problems, and your thoughts on how women with these difficulties can be supported. Discussion between you and your colleagues will be encouraged. The focus group will be audio recorded.

What are the possible disadvantages and risks of taking part?

This study will require you to give up 90 minutes of your time. In addition, difference of opinions may be evident between participants in the focus group. If any conflict occurs, the focus group will be paused and the researcher will ensure that any individual needs are met. If necessary the focus group will finish early to ensure the wellbeing of participants. Staff support resources will be identified prior to the focus group and staff

will be provided with information about services such as Occupational Health if necessary.

What are the possible benefits of taking part?

Although there will be no direct benefit or payment as a result of your involvement in this study, it is hoped that the information you give will contribute to understanding how perinatal mental health staff understand and treat perinatal mental health problems. This may help to develop future guidelines, or contribute to commissioning applications for service development.

What if there is a problem?

If you have any concerns about the study, it might be helpful to discuss these with the researcher, who will do their best to answer your questions. You may also contact either of the researcher's supervisors at the University of Hull. Additionally, there is a formal complaints procedure through the University of Hull which can be accessed by contacting the Associate Dean for Research, Faculty of Health Sciences:

Will my taking part in this study be kept confidential?

Yes, everything you speak about in the focus group will remain anonymous and confidential to anyone outside the group. Non-anonymised information (e.g. signed consent forms, demographics, and contact information) will only be accessible to the researcher and their supervisors, and will be securely stored at the University, separately from recordings and transcriptions. Some direct quotes from the focus group may be used in the write up of the study, but none of your personal details or identifiable information will be included.

Confidentiality may have to be broken if you tell the researcher something which gives us concern for your own or someone else's safety, for example safeguarding issues. In these cases we would usually discuss this with you before any action was taken, but in some cases the researcher may need to tell someone about these concerns without asking you first.

What will happen to the results of the study?

After the study is completed, the results will be written up as part of the researcher's thesis and may be submitted for publication in an academic journal or presented at conferences. Some direct quotes from the focus group may be used in the write up of the study, but none of your personal details or identifiable information will be included.

Who is organising and funding the research?

The researcher is a doctoral student in Clinical Psychology at the University who is also employed by the Humber NHS Foundation Trust. This study is part of her doctoral research project. Research expenses are being provided by the University of Hull.

Who has reviewed the study?

Independent Research Ethics Committees protect the interests of people who participate in research. This study has been reviewed by the School of Health and Social Work Ethics Committee at the University of Hull, and the Research team at Humber NHS Foundation Trust through the Integrated Research Application System, and has received a favourable opinion.

Further information and contact details

If you have any questions, you can:

- Ask your team manager to pass on any queries to the researcher

- Ask your team manager to pass on your contact details so the researcher can contact you to discuss the study

- Contact the researcher via the details below

Contact Details

Researcher: Madeline Steele

Clinical Psychology Programme

School of Health and Social Work

Aire Building

University of Hull

Cottingham Road

Hull

HU6 7RX

Email: M.Steele@2015.hull.ac.uk

Research Supervisors

Dr Lesley Glover   Professor Julie Jomeen

Email: L.F.Glover@hull.ac.uk   Email: J.Jomeen@hull.ac.uk

01482 464117   01482 464581

(Address as above)   (Address as above)

Thank you very much for your interest!

Participant Consent Form

Centre Number:

Study Number:

Participant Identification Number for this trial:

CONSENT FORM

Title of Project: **Exploring how staff construct their understanding of perinatal**

mental health problems

Name of Researcher: **Madeline Steele**

Please initial all

boxes

1. I confirm that I have read and understand the information sheet dated

    4.7.17 (version 1.2) for the above study. I have had the opportunity to

    consider the information, ask questions and have had these answered

    satisfactorily.

2. I understand that my participation is voluntary and that I am free to

    withdraw at any time without giving any reason.

3. I understand that an audio recording of the focus group will be taken, and

    that it will not be possible to extract my individual data from the study once

    I have participated in the focus group. I understand that this data will be

    kept securely and destroyed once the study has finished.

4. I understand that anonymised direct quotations may be used in the write-up of the study and possible subsequent publication. I have been informed that any quotations will not be linked to any personal identifiable information.

5. I agree to take part in the above study.

Name of Participant	Date	Signature

Name of Person taking consent.	Date	Signature

Appendix I

Examples of Topics Covered in Focus Groups

- What does perinatal mental health and being well during the perinatal period mean to you?

- What is your understanding of what causes perinatal mental health problems?

- How does your service work? (referrals, assessments, interventions, discharges)

- How would you want your service to be in an ideal world?

- What are your perceptions of the current NICE guidelines for the treatment of perinatal mental health?

Appendix J

Reflective Statement

This statement aims to comprise my reflections on the research process: where I began, my experiences, what I intend to take forward, and what I would have done differently knowing what I now know.

Choosing a research topic was simultaneously my favourite and the most tedious part of the process for me as I enjoy thinking around topics and exploring the current research, but am prone to getting lost down 'rabbit holes' in the literature and losing my direction. I also struggled to narrow my focus to an appropriate scope for a thesis project. When I thought I had managed this, I discovered nobody was available to supervise me in this area! And so I began the process again, this time able to enact what I had learned from my first experience: namely, always reading with a question in mind. I also began using spreadsheets to keep track of literature trails I was following, so when I found myself off-topic I could trace my way back to the last relevant paper.

In hindsight, I can see that at in the early stages of the research process I was reading literature with my own views strongly in my mind, rather than taking a curious stance. This caused problems with my research question and design for my empirical paper – they never quite felt like they fit. I put work on my empirical on hold for a while to focus on my systematic literature review, and when I came back to it conducted a more thorough literature search and acknowledged that not all the research fit my expectations. This allowed me to take a more exploratory stance using thematic analysis, rather than shoehorning my research into a critical discourse analysis to prove a hypothesis around constructions of mental illness. From then on the process flowed much more smoothly. A pivotal factor in my change in approach was meeting with perinatal mental health staff in person, as this helped me to contextualise my research and think about it in a more balanced fashion. It also made it all seem real, rather than a theoretical exercise – a scary but necessary moment!

My focus and question for my systematic literature review were another matter entirely. Every idea I had seemed to have already been covered, and I had grown frustrated with the situation. Again, I put it to one side. Later, while discussing plans for my empirical study with a perinatal mental health team, a staff member made a comment about the service seeing far more women with personality disorders than they had anticipated when they set up the service. Staff described not knowing what to do

when those referrals came through as they had little training in the area and did not know what the research said about personality disorders in the perinatal period. Having a research question based in clinical practice was a strong motivational factor for me as I felt my research would make a difference to clinicians and to women in their care. I also found it made the write-up flow more smoothly as I had a clear rationale in my mind.

The ethical approval process was for me the hardest part of the research. On reflection, I think I was rather avoidant of working on my ethics application because I struggled to understand the complexities of it, and because it all seemed so far off – I felt like I had enough time to bump it down the to-do list. I'm sure nobody reading this is surprised to learn that I did not have time! My most valuable lesson was to speak to staff at Research and Development teams on the phone; they are in my experience invariably helpful and it makes the process much faster if you have queries about what you need to do to obtain approval.

The experience of recruitment was mixed, with it being enjoyable to talk to perinatal staff teams and share the enthusiasm for my research, but frustrating when it took a long time to go back-and-forth with getting the required approvals, sharing information and organising dates. This was compounded by the ethical approval process as it was not as straightforward as being able to begin recruitment and conduct focus groups as soon as I had gained ethical approval. As there was typically only one perinatal mental health service per Trust, I had to obtain a separate letters of access from each Trust's Research and Development department for each focus group that I wanted to conduct. I could only obtain this letter of access once I had contacted the perinatal mental health team to confirm they were interested in participating. The process to obtain the letter of access sometimes then took a couple of months, during which time contact with teams could be lost, or teams no longer had capacity to participate. In trying to keep my research manageable, I only initially gained Letters of Access to conduct focus groups at 3 Trusts. This became a problem when one team had to withdraw, as I had little time in which to recruit another group and did not want to over-recruit as I did not feel I would have time to gather and analyse the resulting data. However, this lead me to feel pressured to book a provisional date for my final focus group before I had my Letter of Access; when this then did not come through and I had to postpone the group, I ended up inadvertently delaying my research further as to coordinate participants' diaries we had to plan at least a month in advance. Had I

initially recruited more staff teams, I would have had a contingency plan for if groups fell through, and having additional groups to transcribe and analyse would on balance have been less work than last-minute recruitment, and would have contributed positively to the research.

Once I had made it to the point of conducting focus groups I found my direction and motivation again (having somewhat lost it during the process of ethical approval and recruitment), and again the most important factor in this was feeling as through I could contribute something useful to the knowledge base. I noticed a difference in my sense of capability in the first two focus groups as compared to the third, which I found interesting – the first two were during a period where my research was my full focus, and the third was after I had just started a new placement and was juggling adjustment to the change with thesis work and additionally applying for jobs. It made me realise how much harder I found it to do my research thoroughly when my attention was split: for this reason I decided to take my remaining research leave as a big chunk and immerse myself in my work without distractions. This worked well for me and enabled me to complete the analysis process without losing sight of where I was going with it.

Much of the write up was completed within this block of research leave, and I found this to be quite an enjoyable process. I would note that it would have been more helpful to have taken the leave slightly earlier to allow for more time for supervisors to read and comment on drafts. However I feel that as with any large piece of work, writing up will expand to fill the time available: had I taken time off to write it earlier, I probably would still have finished my drafts at the same time! I also wonder if completing much of the write up during this block meant my research became more susceptible to bias, as there was less time to reflect on things either alone or in supervision. I think that this would differ between people: for myself, immersion in the data while I was analysing it meant I had the capacity to consider alternative viewpoints. I was also fortunate that one of my supervisors was able to offer me additional support during this time, and that my peers were also available to bounce ideas off and ensure my viewpoint had not become too narrow.

I knew going in to the research that supervision would be crucial for me to succeed, however I now have a new-found appreciation for the skills involved in being a supervisor: namely being able to simultaneously reassure someone, guide them without spoon-feeding them, and leave them feeling empowered enough to answer their own questions! I noticed a clear pattern in my motivation and confidence between

supervision sessions – it would begin to trail off a few days' work after supervision, and I would invariably arrive at supervision feeling disheartened, disenchanted and incapable. Every time, I left feeling inspired, re-energised and as though I knew what I was doing.

Something else I noted during the write up is that after having conducted my own research, I found it much easier to critique other people's – to the extent where I had to rewrite my entire introduction because I understood the literature base differently. This is a skill I am grateful for as it will enable me to critically appraise evidence and apply this to my practice, which will be beneficial as I qualify and begin working in areas of practice which I may be unfamiliar with from training. The aspect of service development that this research has covered has also given me useful insights which will become more applicable as I progress to a band 7 and gain more responsibility and potentially more involvement in the development of services.

This feels like a good place to be as the end to my training draws near: humbled by the complexities of the research process, more fluent in skills such as critical appraisal and academic writing, and secure in the knowledge that I can take on tasks as big as a thesis and work through the difficulties to come through on the other side.

Appendix K

Example of Data Analysis

Code	Theme	Transcript	Initial comments
Non-specialist staff overlook Risk Person centred Attachment Positivity	Risk Risk Ways of practising Mother's context Finding meaning	**P7:** I think that acute wards which perhaps discharge patients sooner than the mother and baby unit would particularly and I think that sometimes mums when they go back home and they're faced with the pressure of daily life including now looking after a baby, that perhaps that that can be an additional stressor which can cause relapse, whereas if they're able to get better with baby we're able to kind of promote that and a recovery process together, so it kind of negates that a bit more in that sense **R:** it sounds like it would be more sustainable afterwards **P7:** yeah **R:** rather than taking someone completely out of their situation and then throwing them back into it with nothing much changed **P7:** mhm, yep	Relapse prevention, stressors of daily life

		R: that makes sense	
Big job small time	Service context	**P7:** and I think that that's something that's more complex about perinatal is that the, impact of the relationship on the mother and child is actually quite often intertwined in the mental health difficulties with quite a lot of the women as well, so if they're able to get better with the baby it helps with that rather than separating and just sort of avoiding the problem if that makes sense	Relationship and mental health linked
Specialist	Service context		
Resources	Service context		
Baby as intervention point	Ways of practising		
		R: yeah, can you tell me a bit more about that, how those difficulties might be intertwined?	
History	Mother's context	**P7:** um... I think there's a lot of, when women have babies a lot of like their childhood and parenting sort of comes to the fore so if they've had perhaps a traumatic childhood that that can be something that increases anxiety levels perhaps retraumatises them when they give birth and things too, yeah I think that that's one of the ways, feel free to chip in	
		Chorus: [laughter]	
Mother's value Stigma	Mother's context	**P5:** I think there's also a general belief sort of if you don't work in perinatal mental health that if you suffer from a perinatal mental illness you shouldn't be allowed to be a mum, there's still	Stigma, threat, pressure

Multiagency	Mother's context	that sort of general belief in services at large, and within some mental health services and within local authority	
		R: so that's a big burden for a mother to carry	
	Service context	**P5:** it is, but I think for perinatal mental health services they're trying to improve the outcomes and trying to bridge that gap it's also quite challenging, because we don't, it's not only us looking after mums and their babies it's also being able to challenge social perception, negotiate with the local authority other people etc. and change their views as well	Intervention point following from stigma

Appendix L

Example of Supporting Quotes for Themes and Subthemes

Theme	Subtheme	Examples of supporting quotes[1]
Service context	Specialist not integrated	*'generally if they've been discharged where there's a community mental health service, they're more likely to get referred when the other baby comes along'*
		'if we will be integrated into uh, community teams or other things, this thing will happen with the crisis team the crisis team was, crisis team and home intensive treatment team, they've never had capacity for home treatment because everything was driven by the crisis priority, so-... so integrating into community teams practically we will be swallowed up by doing other type of assessment because these ladies is still well, don't worry, wait until they are practically killing themselves and jumping off [bridge] with the baby, this will be the approach'
		'real specialism, and I think that it's just understanding the more subtler nuances of working with women and families really, that have suffered from mental illness and how, how you can work with everybody to produce better outcomes as well, I'm not sure that that's perhaps done quite as much with the sort of more generic mental health service'
		'thinking about the child, and about family dynamics, and relationships, that kind of stuff, is not something

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[1] These quotes are only some of the accounts supporting the themes

that you usually think about in general services, general adult services'

'it's such a great amount of work that you, I don't think would be possible to do if it's integrated'

'there's, sort of, problems with CMHTs alone, covering perinatal mental health problems, cause generally they don't have the, um, um, there's a word for it isn't the the breadth of experience, there isn't enough perinatal patients for them to get that-; P1: critical mass; P2: -critical mass that's the term, critical mass of patients, and tend to underestimate risk'

'we can pick up those cases which is for other people oh it's just a routine case... we can see the risks, we can see the potential problems, and we can do things differently or advise people to do things differently'

'[name]'s a parent-infant psychotherapist and that's also a skill you wouldn't necessarily have in a general team'

'in perinatal we have a greater understanding of medication during pregnancy and for breastfeeding mums'

'acute wards which perhaps discharge patients sooner than the mother and baby unit would particularly and I think that sometimes mums when they go back home and they're faced with the pressure of daily life including now looking after a baby, that perhaps that that can be an additional stressor which can cause relapse, whereas if they're able to get better with baby we're able to kind of promote that and a recovery process together, so it kind of negates that a bit more in that sense'

'the concept of a prophylactic admission, doesn't really hit the radar of general community mental health teams, whereas with teams who are seeing women day in day out they might realise that just a few days before

and a week or so after the delivery could make all the difference'

Isolation   *'I also think you know a team like this needs to be publicized a bit more you know before I started the placement here I had, you know before Monday I had no idea what you did here'*

'people have said like, why are you going there, it's like the island, it's like a weird island and you'll never return from it'

'I think that's something that's changed over the years, and that's because there's a lot of training that has been provided for services so they're aware of our service and what our referral criteria is'

'a perinatal team sort of on the outskirts of things'

Resources   *'the money's just not there to offer an all-singing all-dancing service to the fathers as well'*
'and the level of resource I think is best kind of showed by the fact that the private sector has not seen it possible to make money out of running a mother and baby unit'

'I think in other services where obviously they've got staff such as nursery nurses for example they've got certain types of skill and expertise, particularly when it comes to bonding you know mother infant bonding and doing maybe sessions you know on that, unfortunately at the moment we don't have that opportunity to offer that'

'I think you know cause of the work that we do, particularly like for example for women at risk of postpartum psychosis in terms of preventative work, um, obviously that has um, you know helping to reduce you know a incident of postpartum psychosis here in [placename], and then the number of women then need to get referred to a mother and baby unit and or get admitted, and home treatment, and that is all the time that that is reducing suffering it's also reducing the you know resources the use of resource'

Temporary focus

'there's a huge amount of funding being sort of allocated to CAMHS services and women's services in particular, to sort of help manage the sort of fallout of perinatal mental illness as a whole'

'top of the agenda being the shiny sexy thing'

'it's difficult to know when you're in it whether it's just this massive ground swell and it's really current, or whether that just feels like that cause now I work here and I think about it and read about it what not, but it feels like perinatal's getting some national attention'

'[discussing everywhere having a perinatal team] P1: I don't think it'll ever happen personally, I know that's really a negative place to come from; P2 I think it'll happen, and then when perinatal mental health falls off the… …agenda being the shiny sexy thing, then we'll probably just get integrated into CMHTs and vanish'